TUFTS HEALTH PLAN SPIRIT MEMBER HANDBOOK EFFECTIVE JULY 1, 2017

TUFTS Health Plan

Commonwealth of Massachusetts
Group Insurance Commission

Introduction

Welcome to Spirit by *Tufts Health Plan*™ ("Spirit"). We are pleased you have chosen this Exclusive Provider Option (EPO) plan. We look forward to working with you to help you meet your health care needs.

This *Member Handbook* describes the Spirit health plan and the benefits Spirit *Members* have for *Covered Services*. **Please note that italicized words in this document have special meanings,** which **are given in the "Definitions" section (Part 8, pages 84-81).**

Spirit is a self-funded plan, which means that the *Group Insurance Commission* ("the *GIC"* or "Commission") is responsible for the cost of the *Covered Services* you receive under it. The *GIC* has contracted with *Tufts Health Plan* (*Tufts HP*) to perform certain services, such as claims processing. However, *Tufts HP* does not insure plan benefits or determine your eligibility for benefits under the Spirit Plan.

The *Spirit Plan* offers care from a network of *Tufts Health Plan Providers,* known as *Tufts Health Plan Spirit Providers*, that is smaller than that of the *Navigator Plan*. In order to receive coverage under this Plan, you must obtain *Covered Services* only from *Tufts HP Spirit Providers* (except as described below).

> **Important:** In this plan, *Members* have access to network benefits only from *Tufts HP Spirit Providers*.* However, *Members* may obtain *Emergency* care (including *Medically Necessary* ambulance/EMS services), and *Urgent Care* services while traveling, from any *Provider*.
>
> To find *Tufts HP Spirit Providers* (including their Specialist tiers, if applicable), view the online *Tufts HP Spirit Provider Directory* at **tuftshealthplan.com/gic** or call Member Services at 800-870-9488.

This is an EPO plan, so you are not required to designate a *Primary Care Provider* (*PCP*) or get a referral for specialty services. However, we encourage you to choose a *PCP.* A *PCP* provides most of your routine care and keeps track of your health history, so he or she can recommend other doctors when you need specialty care. *PCPs* can also advocate for your health and help you get the care you need.

Tufts HP Spirit* Plan *Members have benefits for *Covered Services* according to the terms of this *Member Handbook*. *Tufts HP* administers *Spirit,* which provides the medical and prescription drug benefits described in this Member Handbook. Beacon Health Options (Beacon) administers the Mental Health, Substance Use Disorder and EAP benefits (collectively known as "behavioral health" benefits) for the *Spirit* plan.

Medical Services (continued) –

Details on your coverage and costs for **medical services** are described in "Benefit Overview" (page 11) and "Plan and Benefit Information" (pages 27-29). Please note that you must receive *Covered Services,* except for *Emergency* care or *Urgent Care* while traveling, from a *Tufts HP Spirit Provider* to be covered.

Prescription Drug Benefits -- Your prescription drug benefits, and any requirements you must follow to obtain these benefits, are described in Part 5 (see pages 41-74).

Mental Health, and Substance Use Disorder, and EAP Plan –You and your covered family *Members* are automatically eligible for a full range of confidential and professional behavioral health benefits through Beacon. Your behavioral health benefits, and any requirements you must follow to obtain these benefits, are described on pages 96-115.

Your satisfaction with Spirit is important to us. The **Member Services Department** is committed to excellent service, and we are happy to help you. If you have any questions, please call the Member Services Department at 800-870-9488. Calls to the Member Services Department may be monitored by supervisors to ensure quality services.

Member Identification Card

Members must present their *Member* identification card (*Member* ID card) to *Providers* when they receive *Covered Services* in order for benefits to be administered properly. Your *Member* ID card contains information about your *Copayments* for certain *Covered Services*, as well as important phone numbers to call if you have questions about your medical, prescription drug, or behavioral health benefits. If you lose your *Member* ID card, please call Member Services at 800-870-9488 to request a replacement.

Tufts Health Plan Address and Telephone Directory

TUFTS HEALTH PLAN
705 Mount Auburn Street
Watertown, Massachusetts 02472-1508
Hours: Monday – Thursday 8:00 a.m. to 7:00 p.m. E.T.
Friday 8:00 a.m. to 6:00 p.m. E.T.

IMPORTANT PHONE NUMBERS

Emergency Care

If you are experiencing an *Emergency*, you should seek care at the nearest *Emergency* facility. If needed, call 911 for emergency medical assistance. Massachusetts provides a 911 emergency response system throughout the state. If 911 services are not available in your area, ask your local telephone company about emergency access numbers.

If you have an urgent medical need and cannot reach your physician, you should seek care at the nearest emergency room.

Member Services Department and *Tufts Health Plan* Website

For more information about *Tufts Health Plan* and the self-service options available to you, please visit **tuftshealthplan.com/gic**. For general questions, benefit questions, and information about eligibility for enrollment and billing, call the Member Services Department at 800-870-9488 or visit the *Tufts Health Plan* website.

Behavioral Health Services (page 96-115)

Beacon Health Options ("Beacon") administers behavioral health benefits (mental health, substance use disorder, and the EAP Program) for the Spirit plan. For questions about your behavioral health benefits, or for assistance finding mental health or substance use disorder professionals in your area, call Beacon at 855-750-8980 or visit **beaconhealthoptions.com/gic.**

Services for Hearing Impaired *Members*

If you are hearing impaired, *Tufts HP* provides the following services:

- **Massachusetts Relay (MassRelay): 800-720-3480 or 711**
- **Telecommunications Device for the Deaf (TDD): 711**

Coordination of Benefits (COB) and Worker's Compensation

For questions about coordination of benefits (how *Tufts HP* coordinates its coverage with other health care coverage you may have) and workers' compensation, call the Liability and Recovery Department at 888-880-8699, ext. 21098. The Liability and Recovery Department is available from 8:30 a.m. – 5:00 p.m. Monday through Thursday and from 10:00 – 5:00 p.m. on Friday (ET).

Subrogation

Subrogation may occur if your illness or injury (such as injuries from an auto accident) was caused by someone else. For questions about subrogation, call the Member Services Department at 800-870-9488.

IMPORTANT ADDRESSES

Appeals and Grievances Department

If you need to call *Tufts HP* about a concern or appeal, contact the Member Services Department at 800-870-9488. To submit your appeal or grievance in writing, send your letter to:

Tufts Health Plan
Attn: Appeals and Grievances Department
705 Mount Auburn Street
P.O. Box 9193
Watertown, MA 02471-9193
Fax: 617-972-9509

Note: Italicized words are defined in Part 8.

Translating Services

Translating services for over 200 languages
Interpreter and translator services related to administrative procedures are available to assist *Members* upon request. For no cost translation in English, call Member Services.

Arabic . الهوية طاقةب على المدون الرقم على الاتصال يرجى العربية، باللغة المجانية الترجمة خدمة على للحصول بك الخاصة

Chinese 若需免費的中文版本，請撥打ID卡上的電話號碼。

French Pour demander une traduction gratuite en français, composez le numéro indiqué sur votre carte d'identité.

German Um eine kostenlose deutsche Übersetzung zu erhalten, rufen Sie bitte die Telefonnummer auf Ihrer Ausweiskarte an.

Greek Για δωρεάν μετάφραση στα Ελληνικά, καλέστε τον αριθμό που αναγράφεται στην αναγνωριστική κάρτας σας.

Haitian Creole Pou jwenn tradiksyon gratis nan lang Kreyòl Ayisyen, rele nimewo ki sou kat ID ou.

Italian Per la traduzione in italiano senza costi aggiuntivi, è possibile chiamare il numero indicato sulla tessera identificativa.

Japanese 日本語の無料翻訳については**ID**カードに書いてある番号に電話してください。

Khmer (Cambodian)
សម្រាប់សេវាបកប្រែដោយឥតគិតថ្លៃជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់សមាជិករបស់អ្នក។

Korean 한국어로 무료 통역을 원하시면, ID 카드에 있는 번호로 연락하십시오.

Laotian ສໍາລັບການແປພາສາເປັນພາສາລາວທີ່ບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີທີ່ຢູ່ເທິງບັດປະຈໍາຕົວຂອງທ່ານ.

Navajo Doo bąąh iliní da Diné k'ehjí álnéehgo, hodiilnih béésh bee haní'é bee néé ho'dílzingo nantinígíí bikáá'.

Persian. برای ترجمه رایگان فارسی به شماره تلفن مندرج در کارت شناسائی تان زنگ بزنید

Polish Aby uzyskać bezpłatne tłumaczenie w języku polskim, należy zadzwonić na numer znajdujący się na Pana/i dowodzie tożsamości.

Portuguese Para tradução grátis para português, ligue para o número no seu cartão de identificação.

Russian Для получения услуг бесплатного перевода на русский язык позвоните по номеру, указанному на идентификационной карточке.

Spanish Por servicio de traducción gratuito en español, llame al número de su tarjeta de miembro.

Tagalog Para sa walang bayad na pagsasalin sa Tagalog, tawagan ang numero na nasa inyong ID card.

Vietnamese Để có bản dịch tiếng Việt không phải trả phí, gọi theo số trên thẻ căn cước của bạn.

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SPIRIT BY TUFTS HEALTH PLAN

Medical and Prescription Drug Benefits

Part 1 - Benefit Overview

Welcome to the *Tufts Health Plan* Spirit Plan. We are pleased you have chosen us and look forward to working with you to help meet your health care needs.

Your satisfaction with *Tufts Health Plan* is important to us. If at any time you have questions, please call Member Services at 800-870-9488 and we will be happy to help you.

The below chart summarizes certain important benefits available to Spirit *Members*. **Do not rely on this chart alone.** Be sure to read the benefit explanations in Part 5 (see pages 41-74) for details about *Covered Services* and any applicable restrictions.

Remember, in order to receive *Covered Services*, you must receive care from a *Tufts HP Spirit Provider*.

***Deductibles* and Limits**	
COVERED SERVICES	***Member's* Cost per *Contract Year***
***Day Surgery Copayment* Limit** ☞ Page 29	Limit of four *Day Surgery Copayments* per individual *Member.*
***Inpatient* Care *Copayment* Limit** ☞ Page 28	Limit one *Inpatient Copayment* per individual *Member* per quarter. Waived for readmissions within 30 days of discharge, within the same *Contract Year.*
Medical *Deductible*: ☞ Page 28	$500 per *Member* or $1,000 per family per *Contract Year*. (No family member will pay more than his or her individual Medical *Deductible.*)
Prescription Drug *Deductible* ☞ Page 28	$100 per *Member* or $200 per family per *Contract Year*. (No family member will pay more than his or her individual Prescription Drug Deductible.) Prescription drug *Copayments* apply only after the Prescription Drug *Deductible* is met.
Out-of-Pocket Limit: ☞ Page 29	$5,000 per individual *Member* or $10,000 per family per *Contract Year*. (No family member will pay more than his or her individual *Out-of-Pocket Limit.*)

Covered Services	***Member's* Cost**
Emergency Care	
•Treatment in an *Emergency* room ☞ Page 42	$100 *Copayment* (waived if admitted as an *Inpatient*), then *Deductible*. *Emergency* care is covered up to the *Reasonable Charge* regardless of whether care is provided by a *Tufts Health Plan Spirit Provider.* **Note:** If you are admitted as an *Inpatient* after *Emergency* care, you must call *Tufts Health Plan* at 800-870-9488 within 48 hours to be covered.

Note: Italicized words are defined in Part 8.

Important Notes: Your Benefits

The *Spirit Plan* offers care from a network of *Tufts Health Plan Providers* that is smaller than that of the *Navigator Plan*. *Spirit* members are only covered for care from *Providers* in the Spirit network. The only exceptions are for *Emergency* care, or *Urgent Care* services while you are traveling.

Additionally, if you require *Covered Services* that are not available from a *Tufts HP Spirit Provider*, you may seek care from a non-*Plan Provider* (with the approval of an *Authorized Reviewer*). Please see "*Covered Services* Not Available from a *Tufts HP Spirit Provider*" on page 32 for more information.

Outpatient Office Visit *Copayments*

If you receive *Outpatient* care at an office visit, your Office Visit *Copayment* will vary depending on the type of *Tufts HP Spirit Provider* you see. *PCPs* are not tiered; however, care from specialists and hospitals is tiered based on their *Provider* group's efficiency, practice and referral patterns and participation in the *GIC's* Centered Care Program. (For more information about tiering, visit **tuftshealthplan.com/gic.)** *Cost Sharing* applies as indicated below:

- ***Primary care provider* (*PCP*) –** $20 *Copayment*.
  PCPs include general practitioners, family practitioners, internal medicine specialists, pediatric primary care providers, physician assistants, nurse practitioners, primary care physicians who are also specialists, and obstetrician/gynecologists.
- **Massachusetts Specialists**
  - *Copayment Tier 1 Specialist* (Lowest Cost Share): Participates in the Centered Care Program and provides the most efficient care -- $30 *Copayment*
  - *Copayment Tier 2 Specialist* (Mid-Level Cost Share)*:* Participates in the Centered Care Program and provides less efficient care-- $60 *Copayment*
  - *Copayment Tier 3 Specialist* (Highest Cost Share): Does not participate in the Centered Care Program -- $90 *Copayment*
- **All specialists outside of Massachusetts --** $60 *Copayment*
- ***Limited Service Medical Clinic* or free-standing *Urgent Care Center* that participates in the *Spirit* Plan --** $20 *Copayment*

  Note: *Copayments* for *Urgent Care Services* at all other locations vary depending on the type of *Provider* (*PCP* vs. *Specialist*) you see and the location (for example, *Provider's* office, *Limited Service Medical Clinic*, *Urgent Care Center*, or *Emergency* room) where you receive services.

For a list of *Tufts HP Spirit Providers* (including their Specialist tiers, if applicable), please review the online *Provider* Directory at **tuftshealthplan.com/gic**.

Note: Italicized words are defined in Part 8.

- ***Inpatient* hospital stays** at *Tufts HP Spirit Hospitals* are gropus into *Inpatient* Hospital *Copayment* Levels based on their participation in the Center Care Program and their efficiency of performance. All hospital admissions are subject to the *Inpatient* Care *Copayment* Limit.Tier 1 (Lowest Cost Share): Participates in the Centered Care Program and provides the most efficient care -- **$300** *Inpatient Copayment*
- Tier 2 (Mid-level Cost Share): Participates in the Centered Care Program and provides less efficient care -- **$700** *Inpatient Copayment*

Note: Hospitals that do not participate in the Centered Care Program, but that Centered Care *Providers* refer to, are tiered at the same level as the *Provider* who made the referral.

***Covered Services* outside of the 50 United States –** *Emergency* care services provided to you outside of the 50 United States qualify as *Covered Services*. In addition, *Urgent Care Services* provided to you while traveling outside of the 50 United States also qualify as *Covered Services*. However, any other service, supply, or medication provided outside of the 50 United States is excluded under this plan.

Note: Services received in the U.S. territories are considered to be outside of the United States.

Member Identification Card

Members must present their member identification card (member ID card) to *Providers* when they receive *Covered Services* in order for benefits to be administered properly. Each member ID card contains the following information:

- The amounts you must pay for certain *Covered Services* (for example, your *Copayments* for *Emergency* room visits)
- The toll-free *Tufts Health Plan* telephone number to call if you have questions about your medical and prescription drug coverage under the *Spirit* Plan
- The toll-free Beacon Health Options telephone number to call if you have questions related to the Mental Health, Substance Use Disorder, and EAP coverage under this plan

Some services may require approval by an *Authorized Reviewer* prior to treatment. This is indicated in the chart below by **(AR).** If you fail to obtain prior approval, the Spirit Plan will not cover those services and supplies. For more information, call Member Services at 800-870-9488.

Covered Services	***Member's* Cost**
***Outpatient* Care**	
Autism spectrum disorders – diagnosis and treatment **(AR)** ☞ Page 42	***Habilitative* or rehabilitative care (including applied behavioral analysis), and psychiatric and psychological care:** For services provided by a licensed physical, occupational or speech therapist, see "Treatment of speech, hearing, and language disorders" (page 47) and "Rehabilitative and *Habilitative* physical and occupational therapy services" (page 49). For services provided by a paraprofessional or Board-Certified Behavior Analyst (BCBA) or for psychiatric and psychological care, see "Mental Health, Substance Use Disorder, and Enrollee Assistance Program" section (page 96). **Prescription medications:** Subject to Prescription Drug *Copayment*. See "Prescription Drug Benefit" section (page 63). **Note:** Benefit limits for physical and occupational therapy services do not apply to the treatment of autism spectrum disorders.
Cardiac rehabilitation ☞ Page 43	$20 *Copayment*
Chiropractic services (spinal manipulation) ☞ Page 43	$20 *Copayment* **Limited to a total of one spinal manipulation evaluation and 20 visits per *Contract Year.***
Clinical trials studying potential treatment(s) for cancer or other life-threatening diseases or conditions ☞ Page 43	$20 *PCP Copayment,* $30/60/90 Specialist *Copayment*
Coronary Artery Disease Program ☞ Page 43	10% of the *Reasonable Charge*
Diabetes self-management training and educational services ☞ Page 43	$20 *PCP Copayment,* $30/60/90 Specialist *Copayment*
Dialysis ☞ Page 43	*Deductible,* then covered in full
Early intervention services for a *Dependent Child* ☞ Page 44	Covered in full (not subject to the *Deductible*)

Covered Services	***Member's* Cost**
***Outpatient* Care, continued:**	
Family planning procedures, services, and contraceptives ☞ Page 44	**Office Visit**: Covered in full (not subject to the *Deductible*) ***Day Surgery****:* $250 *Copayment* (applies to all *Covered Day Surgery* services, including those performed at free-standing surgical centers), up to the *Day Surgery Copayment Limit;* then *Deductible* **Note:** Some women's preventive health services, including contraceptives and female sterilization procedures, are covered in full and not subject to the *Deductible*. For more information about which services are considered preventive, see **uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations.**
Infertility services (including up to five attempted ART procedures) **(AR)** ☞ Page 45	**Office Visit:** $20 *PCP Copayment*, $30/60/90 Specialist *Copayment* **All other services:** *Deductible,* then covered in full
Maternity care (includes prenatal & postpartum care) ☞ Page 46	**Maternity care office visits:** • Routine maternity care: Covered in full (not subject to the *Deductible*) • Non-routine maternity care: $20 *PCP Copayment*, $30/60/90 Specialist *Copayment* **Routine maternity-related laboratory tests:** Covered in full (not subject to the *Deductible*) **Maternity-related diagnostic tests (i.e., ultrasounds, and non-routine lab tests):** *Deductible,* then covered in full

Covered Services	***Member's* Cost**
***Outpatient* Care, continued:**	
***Outpatient* medical care**	
Allergy injections ☞ Page 46	Covered in full (not subject to the *Deductible*)
Allergy testing and treatment ☞ Page 46	$20 *PCP Copayment*, $30/60/90 Specialist *Copayment*
Chemotherapy ☞ Page 46	*Deductible,* then covered in full
Diagnostic or preventive screening procedures ☞ Page 46	**Colon or colorectal cancer screening:** Covered in full (not subject to the *Deductible*) **Diagnostic procedure only (i.e., colonoscopies associated with symptoms):** *Deductible*, then covered in full **Diagnostic procedures with treatment/surgery (i.e., polyp removal):** Covered as *Day Surgery* admissions - $250 *Copayment* (applies to all *Covered Day Surgery* services, including those performed at free-standing surgical centers), up to the *Day Surgery Copayment Limit;* then *Deductible*
Diagnostic imaging ☞ Page 46	**General imaging:** *Deductible,* then covered in full **MRI/MRA, CT/CTA, PET and nuclear cardiology (AR):** $100 *Copayment* per day, then *Deductible* **Limit of one *Copayment* per day, even if you visit more than one *Provider*.**

Part 1 - Benefit Overview, Continued

Covered Services	*Member's* Cost
***Outpatient* Care, continued:**	
***Outpatient* medical care, continued**	
Diagnostic testing **(AR)** ☞ Page 46	*Deductible,* then covered in full
EKG testing ☞ Page 46	Covered in full (not subject to the *Deductible*)
Human leukocyte antigen testing ☞ Page 46	*Deductible,* then covered in full
Laboratory tests **(AR)** ☞ Page 46	*Deductible*, then covered in full **Note:** Laboratory tests are covered in full and not subject to the *Deductible* when provided as preventive care services, as defined by the U.S. Preventive Services Task Force. For more information about which services are considered preventive, see **uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations.**
Mammograms ☞ Page 46	Covered in full (not subject to the *Deductible*)
Neuropsychological testing for a medical condition **(AR)** ☞ Page 47	*Deductible*, then covered in full
Nutritional counseling ☞ Page 47	$20 *PCP Copayment,* $30/60/90 Specialist *Copayment* **Note:** Nutritional counseling is covered in full and not subject to the *Deductible* when provided as preventive care services, as defined by the U.S. Preventive Services Task Force. Please see "Nutritional counseling" in Part 5 and **uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations** for more information. **Limit of one initial evaluation and three treatment visits per *Contract Year.***

Part 1 - Benefit Overview, Continued

Covered Services	*Member's* Cost
***Outpatient* Care, continued:**	
***Outpatient* medical care, continued**	
Office visits to diagnose and treat illness or injury, including consultations ☞ Page 47	$20 *PCP Copayment,* $30/60/90 Specialist *Copayment*
Outpatient surgery in a physician's office ☞ Page 47	$20 *PCP Copayment,* $30/60/90 Specialist *Copayment*
Pap Smears (cytology examinations) ☞ Page 47	**Routine annual Pap smears (cytology examinations):** Covered in full (not subject to the *Deductible*) **Diagnostic Pap smears (cytology examinations):** *Deductible,* then covered in full
Radiation therapy and x-ray therapy ☞ Page 47	*Deductible,* then covered in full
Smoking cessation counseling services ☞ Page 47	Covered in full
Treatment of speech, hearing and language disorders (includes speech therapy) **(AR)** ☞ Page 47	$20 *Copayment* **Note:** *Copayments* for the diagnosis of speech, hearing and language disorders vary depending upon the service provided (e.g., x-rays, diagnostic testing, office visits).
Voluntary second or third surgical opinions ☞ Page 47	$20 *PCP Copayment,* $30/60/90 Specialist *Copayment*

Covered Services	***Member's* Cost**
***Outpatient* Care, continued:**	
Preventive health care - Adults (age 18 and over) ☞ Page 48	Covered in full (not subject to the *Deductible*) **Note:** Preventive care services for adults are covered in full and are not subject to the *Deductible*. For more information about which services are considered preventive, see **uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.** *Member* cost sharing does apply to diagnostic tests or diagnostic laboratory tests ordered as part of a preventive services visit.
Preventive health care - *Children* (under age 18) ☞ Page 48	Covered in full (not subject to the *Deductible*) **Note:** Preventive care services for children are covered in full and are not subject to the *Deductible*. For more information about which services are considered preventive, see **uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.** *Member* cost-sharing does apply to diagnostic tests or diagnostic laboratory tests ordered as part of a preventive services visit.
Routine annual gynecological exam ☞ Page 48	Covered in full (not subject to the *Deductible*) Note: Preventive gynecological services are covered in full and are not subject to the *Deductible*. For more information about which services are considered preventive, see **uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.** *Member* cost-sharing does apply to diagnostic tests or diagnostic laboratory tests ordered as part of a preventive services visit.

Covered Services	***Member's* Cost**
***Outpatient* Care, continued:**	
Rehabilitative and *Habilitative* physical (PT) & occupational therapy (OT) services **(AR)** ☞ Page 49	$20 *Copayment* **Limit of 30 visits per *Contract Year* for each type of therapy** **Note:** Limit does not apply to services related to the treatment of autism spectrum disorders.
Urgent Care in a free-standing *Urgent Care Center* ☞ Page 49	$20 *Copayment* for care in a free-standing *Urgent Care Center* **Note:** *Copayments* for *Urgent Care* services in all other locations vary depending upon type of *Provider* (*PCP* vs. *Specialist*) you see and the location (i.e., *Provider's* office, *Limited Service Medical Clinic*, *Urgent Care Center*, or *Emergency* room) in which you receive services.
Vision care services, including: • Routine eye exam ☞ Page 49 • Eye examinations and necessary treatment of a medical condition ☞ Page 49	**Routine eye exam:** $20 *Copayment.* **Limit of one routine eye exam in each 24-month period.** **Note:** Services must be received from an EyeMed network provider. **Eye examinations and necessary treatment of a medical condition:** $20 *PCP Copayment,* $30/60/90 Specialist *Copayment*

Covered Services	***Member's* Cost**
Oral health services	
Emergency dental care ☞ Page 50	**Treatment in an *Emergency* room:** $100 *Copayment* (waived if admitted as an *Inpatient*), then *Deductible* applies
Oral surgery for dental treatment in an *Inpatient* or *Day Surgery* setting **(AR)** ☞ Page 50	***Day Surgery*:** $250 *Copayment* (applies to all *Covered Day Surgery* services), including those performed at free-standing surgical centers) per person per *Day Surgery* admission, up to the *Day Surgery Copayment* Limit; then *Deductible* applies ***Inpatient* care:** Applicable *Inpatient* care *Copayment* (see "*Inpatient* Care" below), then *Deductible* applies
Oral surgical procedures for non-dental medical treatment **(AR)** ☞ Page 50	**Office visit:** $20 *PCP Copayment*, $30/60/90 Specialist *Copayment* ***Day Surgery*:** $250 *Copayment* (applies to all *Covered Day Surgery* services, including those performed at free-standing surgical centers) per person per *Day Surgery* admission, up to the *Day Surgery Copayment* Limit; then *Deductible* applies ***Inpatient* care:** $300/$700 *Inpatient* Copayment (see "*Inpatient* Care" below), then *Deductible* applies

Covered Services	***Member's* Cost**
***Day Surgery*:**	
Day Surgery (includes physician and surgeon services) **(AR)** ☞ Page 50	$250 *Copayment* (applies to all *Covered Day Surgery* services, including those performed at free-standing surgical centers) per person per *Day Surgery* admission, up to the *Day Surgery Copayment* Limit; then *Deductible*
***Inpatient* Care:**	
Including but not limited to: Acute hospital services **(AR)** ☞ Page 51 Transplants **(AR)** ☞ Page 51 Gender reassignment surgery **(AR)** ☞ Page 52 **Note:** Other *Covered Services* related to this benefit, such as *Day Surgery*, *Outpatient* medical care, prescription medications, and mental health care, are covered under the applicable benefits as listed here in the Benefit Overview as well as in the "Mental Health, Substance Use Disorder, and Enrollee Assistance Program" section (Page 96-115) Maternity care ☞ Page 53 Clinical trials ☞ Page 54 Reconstructive surgery and procedures **(AR)** ☞ Page 55	$300/$700 *Inpatient Copayment* (up to the *Inpatient* Care *Copayment* Limit), then *Deductible* applies **Note:** See Part 9 (pages 92-95) for a list of Spirit *Inpatient* Hospitals and their *Copayments*.
Inpatient services for enrolled newborn *Children* who stay in the hospital beyond the mother's discharge ☞ Page 53	*Deductible*, then covered in full

Covered Services	***Member's* Cost**
Other Health Services:	
Ambulance services **(AR)** ☞ Page 56	*Deductible,* then covered in full
Cleft lip or cleft palate treatment and services for *Children* ☞ Page 56	**Medical or facial surgery:** • *Inpatient* services: $300/$700 *Inpatient Copayment* (up to the *Inpatient* Care *Copayment* Limit), then *Deductible* applies • *Day Surgery:* $250 *Copayment* (applies to all *Covered Day Surgery* services, including those performed at free-standing surgical centers) per person per *Day Surgery* admission, up to the *Day Surgery Copayment* Limit; then *Deductible* applies **Oral surgery:** Covered to the same extent as other covered surgical procedures. **Dental surgery or orthodontic treatment and management:** Covered in full (not subject to the *Deductible*) **Preventive and restorative dentistry:** Covered in full (not subject to the *Deductible*) **Speech therapy and audiology services:** $20 *Copayment* **Nutrition services:** $20 *PCP Copayment,* $30/60/90 Specialist *Copayment*
Extended care facility services **(AR)** in: ▪ Skilled nursing facility ▪ Rehabilitation hospital ▪ Chronic hospital ☞ Page 56	**Skilled nursing facility:** *Deductible,* then 20% of the *Reasonable Charge.* **Rehabilitation hospital or chronic hospital:** *Deductible,* then covered in full. **Limit of 45 days per *Member* per *Contract Year* in a skilled nursing facility.**
Home health care **(AR)** ☞ Page 57	*Deductible,* then covered in full
Hospice care ☞ Page 57	*Deductible,* then covered in full
Injectable, infused or inhaled medications **(AR)** ☞ Page 58	*Deductible,* then covered in full

Covered Services	***Member's* Cost**
Other Health Services, continued:	
Medical appliances and Equipment, including: *Durable Medical Equipment* (including *Prosthetic Devices*) **(AR)** ☞ Page 59 Eyeglasses/contact lenses (only the first pair after cataract surgery) ☞ Page 60 Hearing aids ☞ Page 60	***Durable Medical Equipment*** (including *Prosthetic Devices): Deductible,* then covered in full **Eyeglasses/contact lenses:** *Deductible,* then covered in full. **Limited to the first pair of lenses after cataract surgery.** **Hearing aids** • *Members* 21 and under: One hearing aid per ear per prescription change covered in full (not subject to the *Deductible*). **Limit of $2,000 per ear per *Member* every 36 months.** • *Members* 22 and over: First $500 covered in full (not subject to the *Deductible*), then 20% of the next $1,500 (plus any balance). **Limit of $1,700 per *Member* every 24 months.**

Covered Services	*Member's* Cost
Other Health Services, continued:	
Personal Emergency Response System ☞ Page 61	20% of charges **Limit of $50 for installation and $40 per month for rental charges for hospital-based systems**
Private duty nursing care (*Inpatient* and *Outpatient*) **(AR)** ☞ Page 61	*Deductible,* then covered in full **Limit of $8,000 per *Member* per *Contract Year***
Scalp hair prostheses or wigs ☞ Page 61	Covered in full (not subject to the *Deductible*)
Special Medical Formulas, including: Low protein foods ☞ Page 62 Nonprescription enteral formulas **(AR)** ☞ Page 62 Special medical formulas **(AR)** ☞ Page 62	*Deductible,* then covered in full

Prescription Drug Benefit (see pages 63-70)

For information about your *Copayments* for covered prescription drugs, see the "Prescription Drug Benefit" section in Part 5.

Mental Health, Substance Use Disorder, and Enrollee Assistance Program (see pages 96-115)

Benefits administered by Beacon Health Options. For information, see the "Mental Health, Substance Use Disorder, and Enrollee Assistance Program" section on page 96 or call 855-750-8980.

Your Cost for Medical Services

You are responsible for paying the costs described below for *Covered Services*. For more information about the *Covered Services* subject to these costs, please see Part 5.

Covered Services are covered only when the *Covered Services* are provided by a *Tufts HP Spirit Provider*.

If *Tufts HP* determines that a *Covered Service* is not available from a *Tufts HP Spirit Provider*, you may receive *Covered Services* from a *Provider* who is not part of the Spirit network (with the approval of an *Authorized Reviewer*), up to the *Reasonable Charge*. You will be responsible for any charges in excess of the *Reasonable Charge.*

Copayments

- *Emergency* room (waived if admitted).....$100 per visit

  Notes:
  - If you register in an emergency room but leave without receiving care, an *Emergency* Room *Copayment,* (and then the *Deductible*) may apply.
  - A *Day Surgery Copayment* may apply if *Day Surgery* services are received.
  - If you are admitted to an *Inpatient* mental health facility after being seen at the *Emergency* Room, please call the *Tufts Health Plan* Member Services Department to request that your *Emergency* Room *Copayment* be waived, or to request an adjustment of the claim.

- Office Visit.....$20 *PCP Copayment,* $30/60/90 Specialist *Copayment* (see page 19)

  Note: You may be charged an Office Visit *Copayment* for certain *Outpatient* services listed as "covered in full" in the Benefit Overview table (see pages 11-26) if these services are provided in conjunction with an office visit.

- *Inpatient* Services ..... varies by hospital tier (see Part 9).
- *Day Surgery* ..... $250 per admission.

Note: Italicized words are defined in Part 8.

Your Cost for Medical Services, continued

Day Surgery Copayment Limit

Each individual *Member* is responsible for paying a maximum of four *Day Surgery Copayments* per *Contract Year*. (The *Contract Year* runs from July 1 to the following June 30.) When you have paid four *Day Surgery Copayments*, no more *Day Surgery Copayments* will be charged in that *Contract Year.*

The *Day Surgery Copayment* Limit consists of your *Copayments* for *Day Surgery* only. It does not include *Deductibles*, *Coinsurance*, other *Copayments*, or payments you make for non-*Covered Services* or care received from *Providers* who are not part of the Spirit Network.

Inpatient Care *Copayment* Limit

Each individual *Member* is responsible for paying a maximum of one *Inpatient Copayment* per *Contract Year* quarter. (The *Contract Year* quarters are: July/August/September, October/November/December, January/February/March, and April/May/June). The *Inpatient* Care *Copayment* is waived if you are readmitted within 30 days of discharge, if both admissions are in the same *Contract* Year. Contact the *Tufts Health Plan* Member Services Department if you are billed so that we can adjust your claim.

The quarterly *Inpatient* Care *Copayment* includes only *Copayments* for *Inpatient care.* It does not include *Deductibles*, *Coinsurance*, other *Copayments*, or payments you make for non-*Covered Services*.

Medical *Deductible*

A $500 individual *Deductible* and a $1,000 family *Deductible* apply each *Contract Year.* Your family *Deductible* is met once any combination of family *Members* reaches $1,000; no family *Member* will pay more than his or her individual *Deductible* per *Contract Year*.

The *Deductible* is the amount that you must first pay for *Covered Services* before the Spirit *Plan* will pay for certain *Covered Services.* It **does not** apply to prescriptions drugs or care from behavioral health *Providers*. (For more information, see "Mental Health, Substance Use Disorder, and EAP Plan" later in this *Member* Handbook.)

Note: The *Deductible* applies to *Day Surgery*, *Emergency* room*, Inpatient* hospital, and many *Outpatient* services. It also applies to all services and supplies categorized as "Other Health Services," except for hearing aids, Personal Emergency Response Systems, scalp hair prostheses or wigs for cancer and leukemia patients, and chiropractic services (spinal manipulation). See the "Benefit Overview" in Part 1 for more information.

Prescription Drug *Deductible*

A $100 individual Prescription Drug *Deductible* and a $200 family Prescription Drug *Deductible* apply each *Contract Year*. Your family Prescription Drug *Deductible* is met once any combination of family *Members* reaches $200; no family *Member* will pay more than his or her individual Prescription Drug *Deductible* per *Contract Year*.

The Prescription Drug *Deductible* is the amount you must first pay for covered prescription drugs before the *Spirit Plan* will pay for any covered prescription drugs. The amount you accrue towards your *Deductible* when filling a prescription is calculated based *Tufts Health Plan's* contracted rate at the time the prescription is filled and does not reflect any rebates that we may receive at a later date.

Note: This Prescription Drug *Deductible* does **not** apply to smoking cessation agents or to generic buprenorphine-naloxone, naloxone, and naltrexone products.

Your Cost for Medical Services, continued

Coinsurance
There is no *Coinsurance* for most *Covered Services* provided by a *Tufts HP Spirit Provider*.

Certain services do require *Coinsurance*, including: hearing aids for *Members* age 22 and over; extended care services in a skilled nursing facility; Personal Emergency Response Systems; and Coronary Artery Disease Programs. See 'Benefit Overview" (pages 11-26) for details.

Out-of-Pocket Limit
A $5,000 individual *Out-of-Pocket Limit* and a $10,000 family *Out-of-Pocket* limit apply each *Contract Year*. The family *Out-of-Pocket Limit* includes all amounts any enrolled family *Members* pay toward their individual *Out-of-Pocket Limits*, including the *Deductible*, *Coinsurance*, and *Copayments* for *Covered Services*.

Once the family *Out-of-Pocket Limit* has been met, all enrolled family *Members* will have satisfied their individual *Out-of-Pocket Limits* for the remained of that *Contract Year*. Once you satisfy the *Out-of-Pocket Limit,* all *Covered Services* you receive are covered in full up to the *Reasonable Charge* for the rest of that *Contract Year*.

Your *Copayments* for prescription drugs and mental health and substance use disorder services (described in "Mental Health, Substance Use Disorder, and EAP Plan" later in this *Member* Handbook) also count towards this *Out-of-Pocket Limit*.

Note: You cannot use the following services and supplies to satisfy this *Out-of-Pocket Limit:*

- Any service or supply that does not qualify as a *Covered Service*. This includes any services that require the approval of an *Authorized Reviewer* prior to treatment for which you do not obtain such approval.
- Any amount you pay for *Covered Services* obtained from a *Provider* that is not a *Tufts HP Spirit Provider* (except in cases of *Emergency* or for *Urgent Care* while traveling, and except as discussed in the "*Covered Services* not available from a *Tufts HP Spirit Provider"* section on page 32).

Part 3 – How Your Health *Plan* Works

How the *Plan* Works

Eligibility for Benefits
The *Plan* covers only the services and supplies described as *Covered Services* in Part 5. There are no pre-existing condition limitations under this plan. You are eligible to use your benefits as of your *Effective Date*.

In accordance with federal law (45 CFR § 148.180), *Tufts Health Plan* does not:

- Adjust premiums based on genetic information;
- Request or require genetic testing; or
- Collect genetic information from individuals prior to, or in connection with, enrollment in a plan, or at any time for underwriting purposes.

***Medically Necessary* services and supplies**
The *Plan* will pay for *Covered Services* and supplies when they are *Medically Necessary*, as determined by *Tufts Health Plan*. *Covered Services* must be provided by a *Tufts HP Spirit Provider* to be covered. Except as described in the "Important Note" above, *Covered Services* provided by any other *Provider* will not be covered (except for *Emergency* care or *Urgent Care* while traveling, which are covered even when obtained from non-*Plan Providers*).

Note: The Spirit Plan will not pay for services or supplies which are not *Covered Services*, even if they are provided by a *Tufts HP Spirit Provider*.

The Spirit Network

The Spirit *Provider* network is smaller than that of the Navigator Plan. Please confirm that the *Provider* you wish to see is a *Tufts HP Spirit Provider.* The *Plan* will not pay for services or supplies non-*Spirit Providers,* there will be no coverage for services received from that *Provider* (except for *Emergency* care, *Urgent Care* while traveling, and as stated in "*Covered Services* not available from a *Tufts HP Spirit Provider"* on page 32).

To find *Tufts HP Spirit Providers,* please call 800-870-9488 or visit **tuftshealthplan.com/gic**.

***Outpatient* Care**
You are not required to designate a *Primary Care Provider* (*PCP*), but there are many benefits to having a *PCP.* A *PCP* provides most of your routine care and can recommend other doctors to you when you need specialty care. *PCPs* can be advocates for your health, keep track of your health history, and help you get the care you need.

However, you can choose to see any *Tufts HP Spirit Provider* to receive care. When a *Tufts HP Spirit Provider* provides your care, you do not have to submit any claim forms. The claim forms are submitted to *Tufts Health Plan* by the *Tufts HP Spirit Provider*.

You will be required to pay a *Copayment* for certain *Covered Services* you receive from *Tufts HP Spirit Providers*. For more information about your costs for medical services, see "Benefit Overview" and "*Plan* and Benefit Information" earlier in this *Member Handbook*.

Note: Italicized words are defined in Part 8.

Inpatient Care

The Spirit Plan has two different *Copayment* Levels for *Inpatient* hospital stays at *Tufts HP Spirit Hospitals*. *Copayments* vary based on which hospital you choose.

Part 10 provides a list of the *Tufts HP Spirit Hospitals* and their *Copayment* Levels.

Inpatient Hospital Tiering

Inpatient hospital *Copayments* are based on their efficiency of care. (Call Member Services for more information about hospital groupings).

- *Tufts HP Spirit Hospitals* that are most efficient are in ***Inpatient Copayment Tier 1*****,** which has a **$300 *Copayment*** per admission.
- *Tufts HP Spirit Hospitals* that are less efficient are in ***Inpatient Copayment Tier 2,*** which has a **$700 *Copayment* per admission.**
- Transplants at *Tufts Health Plan's* designated transplant network facilities are not grouped in a *Copayment* Level. Covered transplant services at these facilities are subject to a **$300 *Copayment* per admission.** Covered transplant services at any other *Tufts HP Spirit Hospital* have a **$700 *Copayment* per admission.** Call Member Services at 800-870-9488 for information about the designated transplant network.

In addition, there are other services that are not included under these *Copayment* levels. These include *Day Surgery*; certain care for newborn *Children*; and rehabilitation, extended care, and skilled nursing services at a skilled nursing facility, rehabilitation hospital, or chronic care facility. For information about your costs and limits for these services, please see "Benefit Overview" and Part 10 in this *Member Handbook*.

Selecting a *Provider*

In order to receive coverage, you must receive care from a *Tufts HP Spirit Provider* listed in the *Tufts HP Spirit Provider Directory*.

Notes:

- Under certain circumstances, if your physician is not in the *Tufts Health Plan Spirit Network*, you will be covered for a short period of time for services provided by that physician. Please see "Continuity of Care" on page 32.
- For additional information about a *Tufts HP Spirit Provider*, contact the Massachusetts Board of Registration in Medicine at 800-377-0550 or **mass.gov/massmedboard.** The Board of Registration provides information about physicians licensed to practice in Massachusetts.

Missed Appointments

The *Plan* will not pay for missed appointments that you did not cancel in advance (usually at least 24 hours). If the *Tufts HP Spirit Provider's* office provider is to charge for missed appointments that were not canceled in advance, you will have to pay the charges.

Changes to the *Tufts Health Plan* Spirit *Provider* network

Tufts Health Plan offers *Members* a network of physicians, hospitals, and other *Providers* throughout the *Spirit Service Area*. Although *Tufts Health Plan* works to ensure the continued availability of *Tufts HP Spirit Providers*, our network of *Providers* may change during the year.

This can happen for many reasons, including a *Provider's* retirement, the *Provider's* move out of the *Spirit Service Area*, or his or her failure to continue to meet *Tufts Health Plan's* credentialing standards. This can also happen if *Tufts Health Plan* and the *Provider* are unable to reach agreement on a contract.

The Spirit Network, continued

Covered Services* from non-*Plan Providers
Emergency care services from a non-*Plan Provider* qualify as *Covered Services*. In addition, *Urgent Care* services provided to you while you are traveling also qualify as *Covered Services,* even if they are provided by a non-*Plan Provider*. However, you may be billed for charges above the *Reasonable Charge* (as well as the *Deductible* and/or *Copayments*) if you visit an Emergency room or *Urgent Care Provider* that is not in the *Tufts HP* network.

Except as detailed below, any other service, supply, or medication provided to you by a non-*Plan Provider* is excluded under this plan.

Covered Services* Not Available from a *Tufts HP Spirit Provider
If *Tufts Health Plan* determines that a *Covered Service* is not available from a *Tufts HP Spirit Provider*, with *Tufts Health Plan's* prior approval, you may go to a non-*Plan Provider* and receive *Covered Services* up to the *Reasonable Charge*. You are responsible for any charges in excess of the *Reasonable Charge* (as well as any applicable *Cost Sharing Amount*). You may receive a bill for these services. If you do receive a bill, please call Member Services or see "Bills from *Providers*" in Part 6 for more information about what to do if you receive a bill.

Continuity of Care

If you are an existing *Member*
If your *Provider* disenrolls from the *Plan*, we will provide you notice at least 30 days in advance. If the disenrollment is for reasons other than quality or fraud, you may continue to see your *PCP* for up to 30 days after the disenrollment in the following circumstances:

- **Pregnancy**. If you are in your second or third trimester of pregnancy, you may continue to see your *Provider* through your first postpartum visit.

- **Terminal Illness.** If you are terminally ill (having a life expectancy of 6 months or less), you may continue to see your *Provider* as long as necessary.

To choose a new PCP, call Member Services at 800-870-9488 or visit **tuftshealthplan.com/gic.**

If you are enrolling as a new *Member*
If your *Provider* is not included in one of the *Group Insurance Commission's* health plans at the time of your enrollment as a new *Member*, you may continue to see him or her if:

- **Undergoing Treatment/PCP.** If you are undergoing a course of treatment, or the *Provider* is your *PCP*, you may continue to see your *Provider* for up to 30 days from your *Effective Date*.
- **Pregnancy.** If you are in your second or third trimester of pregnancy, you may continue to see your *Provider* through your first postpartum visit.
- **Terminal Illness.** If you are terminally ill, you may continue to see your *Provider* as long as necessary.

Conditions for coverage of continued treatment
As a condition for coverage of continued treatment, *Tufts Health Plan* may require your *Provider* to agree to:

- Accept reimbursement from the *Plan* at the rates applicable prior to notice of disenrollment as payment in full, and not to impose *Member* cost sharing in an amount exceeding the cost sharing that could have been imposed prior to the *Provider's* disenrollment
- Adhere to the quality assurance standards of the *Plan*, and to provide the *Plan* with any necessary medical information; and
- Adhere to the *Plan* policies and procedures, including those regarding referrals, prior authorization, and providing services pursuant to a treatment plan approved by the *Plan*.

Financial Arrangements between *Tufts Health Plan* and *Tufts HP Spirit Providers*

Tufts Health Plan's goal in compensating *Tufts HP Spirit Providers* is to encourage preventive care and active management of illnesses. *Tufts Health Plan* strives to be sure that the financial reimbursement system we use encourages appropriate access to care and rewards *Providers* for taking the best care of our *Members*. *Tufts Health Plan* uses a variety of mutually agreed upon methods to compensate *Tufts HP Spirit Providers*.

The *Tufts HP Spirit Provider Directory* indicates the method of payment for each *Provider*. Regardless of the method of payment, *Tufts Health Plan* expects all participating *Providers* to use sound medical judgment when providing care and when determining whether a referral for specialty care is appropriate. This approach encourages the provision of *Medically Necessary* care and reduces the number of unnecessary medical tests and procedures, which can be both harmful and costly to *Members*.

Tufts Health Plan reviews the quality of care provided to *Members* through its Quality of Health Care Program. You should feel free to ask your *Provider* specific questions about how he or she is paid.

Member Identification Card

The *Plan* gives each *Member* a Member Identification card (*Member* ID card). Your *Member* ID card identifies your health care plan and your individual Member Identification Number.

When you receive your *Member* ID card, check it carefully. If any information is incorrect, call Member Services at 800-970-9488.

Please remember to carry your card with you at all times and bring it to your medical appointments. When you receive services, you must tell the office staff that you are a *Tufts Health Member.*

Note: If you do not identify yourself as a *Member,* and as a result, your *Provider* and/or the *Plan* does not manage your care, then the *Plan* may not pay for the services provided. If this occurs, you may be responsible for the costs.

Utilization Management

The purpose of *Tufts Health Plan's* utilization management program is to ensure that health care services provided to *Members* are *Medically Necessary* and provided in the most appropriate and efficient manner. Under this program, *Tufts Health Plan* may use prospective, concurrent, and/or retrospective review of health care services.

Type of Review	Timeframe for Determinations*
Prospective (Pre-service) • *Tufts Health Plan* determines whether proposed treatment is *Medically Necessary*	15 days
Concurrent • The *Plan* monitors the course of treatment as it occurs and determines when it is no longer *Medically Necessary*.	Determination is made prior to treatment being reduced or terminated to allow you to appeal the determination.
Retrospective (Post-service) • The *Plan* evaluates care after it has been provided, and to more accurately determine the appropriateness of health care services provided to *Members.*	30 days
Urgent care review	72 hours

If your request for coverage is denied, you have the right to file an appeal. See Part 6for information on how to file an appeal.

Tufts HP makes coverage determinations. You and your *Provider* make all treatment decisions.

Notes: *Members* can call the Member Services Department at 800-870-9488 to determine the status or outcome of utilization review decisions.

Utilization review for behavioral health (mental health and substance use disorder) services is conducted by Beacon Health Options. See the "Mental Health, Substance Use Disorder, and Enrollee Assistance Programs" section later in this *Member Handbook* or call Beacon at 855-750-8980.

Care Management

Some *Members* with severe illnesses and injuries may receive interventions under *Tufts Health Plan's* case management program.

Severe illness and injuries may include, but are not limited to, the following:

- High-risk pregnancy and newborn *Children*
- Serious heart or lung disease
- Cancer
- Certain neurological diseases
- AIDS or other immune system diseases
- Severe traumatic injury

Under this program, the *Plan*:

- Supports *Members'* treatment and progress
- Encourages the use of the most appropriate and cost-effective treatments

If a *Member* is identified by *Tufts Health Plan* as an appropriate candidate for care management or is referred to the program, *Tufts Health Plan* may contact *Members* and their *Providers* to:

- Discuss a treatment plan
- Established prioritized goals.
- Explore potential alternative services or supplies.

Members and their *Plan Providers* will be contacted if *Tufts Health Plan* identifies alternatives to the *Member's* current treatment plan that qualify as *Covered Services*, are cost effective, and are appropriate for the *member*

Individual case management (ICM)

In certain circumstances, *Tufts Health Plan* may authorize an individual case management ("ICM") plan for *Members* with a severe illnesses or injuries. The goal of the ICM plan is to identify and arrange for the most appropriate type, level, and setting of health care services and supplies for these *Members*.

Under the ICM plan, *Tufts Health Plan* may authorize coverage for alternative services and supplies that do not otherwise constitute *Covered Services* for that *Member*. This will occur only if *Tufts Health Plan,* at its sole discretion, determines that all of the following conditions are satisfied:

- The *Member's* condition is expected to require medical treatment for an extended time
- The alternative services and supplies are:
  - *Medically Necessary*;
  - Provided directly to the *Member* with the condition
  - In place of more expensive treatment that is a *Covered Service*.
- The *Member* and an *Authorized Reviewer* agree to the alternative treatment program
- The *Member* continues to show improvement in his or her condition, as determined periodically by an *Authorized Reviewer*.

When *Tufts Health Plan* authorizes an ICM plan, the *Covered Service* that the ICM plan will replace will also be indicated. The benefit available for the ICM plan will be limited to the benefit that the *Member* otherwise would have received for the *Covered Service.*

Tufts Health Plan will periodically monitor the appropriateness of the alternative services and supplies provided to the *Member*. If, at any time, these services and supplies fail to satisfy any of the conditions described above, the *Plan* may modify or terminate coverage for the services or supplies provided under the ICM plan

Authorized Reviewer Approval

Certain *Covered Services* require prior approval from an *Authorized Reviewer.* These services are identified by **(AR)** in the "Benefit Overview".

If you receive these services from a *Tufts HP Spirit Provider,* your *Provider* is responsible for obtaining approval from an *Authorized Reviewer*. If you fail to obtain prior approval, the Spirit Plan will not cover those services and supplies.

For more information about how to obtain this prior approval, please call Member Services at 800-870-9488.

If a request for coverage is denied, you have a right to appeal. Please see Part 6, "*Member* Satisfaction Process", for information on how to file an appeal.

Services that you receive in an *Emergency* do not require prior approval from an *Authorized Reviewer.*

Part 4 - Enrollment and Termination Provisions

Enrollment

When to Enroll
As a *Subscriber*, you may enroll yourself and your eligible *Dependents*, if any, for this coverage. You must apply to the *GIC* for enrollment in the *Plan.* To obtain the appropriate forms, active employees should contact their *GIC* Coordinator, and retirees should contact the *GIC.*
You and your eligible *Dependents*, if any, may enroll for this coverage only:

- Within 10 days of your hire date as an eligible new employee
- During the Annual Enrollment Period
- Within 60 days of the date your *Dependent* is first eligible for this coverage.

You must complete an enrollment form to enroll or add *Dependents* in a *Family Plan*. Additional documentation may be required, as follows:

- Newborns and *Dependent Children* (including stepchildren) under age 26: copy of hospital announcement letter (for a newborn) or the *Child's* certified birth certificate
- Adopted *Children*: photocopy of proof of placement letter or adoption
- Foster *Children* ages 19-26: photocopy of proof of placement letter or court order
- *Spouses:* copy of certified marriage certificate

Enrollment is subject to the provisions of Massachusetts General Laws, Chapter 32A, the *GIC* Rules and Regulations, and applicable federal law.

Additional Information about Newborn *Children*
The *Plan* will cover your newborn *Child* from birth under a *Family Plan,* provided the *Subscriber* enrolls the newborn *Child* within 60 days after birth.

If the *Subscriber* does not enroll the newborn *Child* within 31 days after birth, the Spirit Plan will only cover that newborn *Child* at birth for an initial 31-day period. During this period, the Spirit Plan will only cover *Routine Nursery Care* for up to 48 hours (in the case of a vaginal delivery) or up to 96 hours (in the case of a caesarean delivery).

To continue coverage for the newborn *Child* after this 31-day period, **the *Subscriber* must apply to enroll the *Child* within 60 days after birth.**

Special Enrollment Condition
If you declined to enroll your spouse or *Dependents* when first eligible, you and your eligible *Dependents* may be enrolled within 60 days of a qualifying status change even ("qualifying events") or during the *GIC's Annual Enrollment Period*. Qualifying events include the following:

- Your coverage under the other health coverage ends involuntarily
- Your marriage or divorce
- The birth, adoption, or placement for adoption of your *Dependent Child*
- The employee or *Dependent* is eligible under a state Medicaid plan or state children's health insurance program (CHIP), and the Medicaid or CHIP coverage is terminated.
- The employee or *Dependent* becomes eligible for a premium assistance subsidy under a state Medicaid plan or CHIP

To obtain *GIC* enrollment and change forms, active employees should contact the *GIC* Coordinator at their workplace, and retirees should contact the *GIC*. Enrollment and change forms are also available on the *GIC's* website at **mass.gov/gic.**

Handicapped Child
Coverage is available under a *Family Plan* for a *Handicapped Child* over the age of 25, provided that the *Child* was either mentally or physically handicapped so as not to be capable of earning his or her own living before age 19. Contact the *GIC* at 617-727-2310, ext. 5, for an application to continue coverage for a *Handicapped Child*.

Coverage may also be available until age 26 for *Children* who become handicapped at age 19 or older. Contact the *GIC* for information.

Note: Italicized words are defined in Part 8.

Effective Date of Coverage

New employees
Coverage begins on the first day of the month following 60 days or two (2) calendar months of employment, whichever comes first.

Persons applying during an *Annual Enrollment Period*
Coverage begins each year on July 1.

Spouses and Dependents
Coverage begins on the later of:

- The date your own coverage begins, or
- The date that the *GIC* has determined your spouse or dependent is eligible.

Surviving *Spouses*
Upon application, you will be notified by the *GIC* of the date your coverage begins.

Residence in *Service Area* Requirement
Every individual covered by a *Family Plan* must reside in the *Plan's Spirit Service Area* for at least 9 months of the year, except for **full-time students**. Please contact the *GIC* at 617-727-2310, ext. 1 if your *Dependent(s)* do not reside in the *Plan's Spirit Service Area*.

Termination

Subscribers

Your coverage ends on the earliest of:

- The end of the month in which you cease to be eligible for coverage
- The date of death
- The date the surviving *Spouse* (or covered former *Spouse*) remarries
- The end of the month covered by your last contribution toward the cost of coverage
- The date the *Plan* terminates
- The date a *Subscriber* becomes eligible for Medicare and retires (or is already retired). Contact the *GIC* for more information about the options to continue health care coverage in one of the *GIC's* Medicare health plans.
- The date the *Subscriber* moves out of the *Spirit Service Area*. In order to remain enrolled in the Spirit plan, the *Subscriber* must remain in the *Spirit Service Area* for 9 months in each *Calendar Year.*

Dependents
A *Dependent's* coverage ends on the earliest of:

- The date the *Subscriber's* coverage under the *Plan* ends
- The end of the month covered by your last contribution toward the cost of coverage
- The date you become ineligible to have a *Spouse* or *Dependents* covered
- The end of the month in which the *Dependent* ceases to qualify as a *Dependent*
- The date the *Dependent Child*, who was permanently and totally disabled by age 19, marries
- The date the covered divorced *Spouse* remarries (or the date the *Subscriber* marries)
- The date of the *Spouse* or *Dependent's* death
- The date the *Plan* terminates
- The date the *Spouse* of a retired *Subscriber* becomes eligible for Medicare. Contact the *GIC* for more information about the options to continue health care coverage in one of the *GIC's* Medicare health plans.

Continuation of Coverage

Option to Continue Coverage for *Dependents* Age 26 and Over
Dependent Children age 26 and over are no longer eligible for coverage under this *Plan*. *Dependents* age 26 and over who are full-time students at accredited educational institutions may continue to be covered. However, you must pay 100% of the individual premium. The student must also submit an applicable to the *GIC* no later than 30 days after his or her 26th birthday. If this application is submitted late, your *Dependent Child* may apply during the *GIC's* annual enrollment period. Full-time students age 26 and over are not eligible for continued coverage if there has been a two-year break in their *GIC* coverage.

Continuing Coverage for Surviving *Spouses* and *Dependent Children*
In the event of the death of the *Subscriber*, the surviving *Spouse* and/or eligible *Dependent Children* may be able to continue coverage. For more information on eligibility for survivors and orphans, contact the *GIC.*

To continue coverage, you must submit an enrollment form to the *GIC* within 30 days of the covered employee or retiree's death. You must also make the required contribution toward the cost of the coverage. Coverage will end on the earliest of:

- The end of the month in which the survivor dies
- The end of the month covered by your last contribution payment for coverage
- The date the coverage ends
- The date the *Plan* terminates
- For *Dependents:* the end of the month in which the *Dependent* would otherwise cease to qualify as a dependent.
- The date the surviving *Spouse* remarries

Option to Continue Coverage after a Change in Marital Status
Your former *Spouse* will not cease to qualify as a *Dependent* under the *Plan* solely because a judgment of divorce or separate support is granted. Massachusetts law presumes that he or she continues to qualify as a *Dependent,* unless the divorce judgment states otherwise.

If you get divorced, you must notify the *GIC* within 60 days and send the *GIC* a copy of the following sections of your divorce decree: Divorce Absolute Date, Signature Page, and Health Insurance Provisions. **If you or your former *Spouse* remarries, you must also notify the *GIC*.** If you fail to report a divorce or remarriage, *Tufts Health Plan* and the *GIC*, have the right to seek recovery of health claims paid or premiums owed for your former *Spouse*.

Under M.G.L. Ch. 32A as amended and the *GIC's* regulations, your former *Spouse* will no longer qualify as a dependent after the earliest of these dates:

- The end of the period in which the judgment states he or she must remain eligible for coverage
- The end of the month covered by the last contribution toward the cost of the coverage
- The date he or she remarries
- The date you remarry. If your former *Spouse* is covered as a dependent on your remarriage date, and the divorce judgment gives him or her the right to continue coverage, coverage will be available at full premium cost (as determined by the *GIC*) under the divorced *Spouse* rider. Alternatively, your former *Spouse* may enroll in COBRA coverage.

***Family Members* of *Subscribers* Enrolled in Medicare**
When a retired *Subscriber* turns 65 years of age and becomes eligible to enroll in the Medicare Program (Parts A and B), the *Subscriber's* family *Members* who are under age 65 may stay on the *Plan* provided that the *Subscriber* enrolls in one of the *GIC's Tufts Health Plan Medicare* plans.

COBRA Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law under which certain former employees, retirees, spouses, former spouses and dependent children have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called 'Qualifying Events.' If you elect COBRA coverage, you are entitled to the same coverage being provided under the GIC's plan to similarly situated employees or dependents. The GIC administers COBRA coverage.

For more information about COBRA coverage, please see "Group Insurance Commission Notices" beginning on page 116.

Coverage under an *Individual Contract*

Under certain circumstances, a person whose *Group Insurance Commission* coverage is ending has the option to convert to an *Individual Contract*. Please note that conversion to non-group health coverage may offer less comprehensive benefits and higher member cost-sharing than either COBRA coverage or plans offered under the Health Insurance Marketplaces in many states.

If you live in Massachusetts:
If your *Group Insurance Commission* coverage ends, you may be eligible to enroll in coverage under an *Individual Contract* offered either directly by *Tufts Health Plan* or through the Commonwealth Health Insurance Connector Authority ("the Connector"). For more information, call Member Services or contact the Connector by phone at 877-MA-ENROLL or on its website at **mahealthconnector.org.**

If you live outside of Massachusetts
If your *Group Insurance Commission* coverage ends, you are not eligible to enroll in coverage under an *Individual Contract* offered either directly by *Tufts Health Plan* or through the Commonwealth Health Insurance Connector Authority. Please contact your state insurance department for information about coverage options that are available to you in your state.

For more information
Please call *Tufts Health Plan* Member Services at 800-870-9488.

Part 5 - Covered Services

Covered Services

Health care services and supplies are *Covered Services* only if they are:

- Listed as *Covered Services* in this Part 5
- *Medically Necessary*, as determined by *Tufts Health Plan*
- Consistent with applicable law
- Consistent with *Tufts Health Plan's Medical Necessity* Guidelines in effect at the time the services or supplies are provided. This information is available to you at **tuftshealthplan.com** or by calling Member Services at 800-870-9488
- Obtained from a *Tufts HP Spirit Provider,* except for:
  - *Emergency* or *Urgent Care* services while traveling.
  - Other *Covered Services* received from non-*Plan Providers* (subject to the requirements listed under "*Covered Services* Not Available from a *Tufts Health Plan Spirit Provider*" on page 32)
- Provided to treat an injury, illness or pregnancy, or are preventive care services
- Approved by an *Authorized Reviewer* (if applicable)

Notes:

- Certain *Covered Services* require prior approval from an *Authorized Reviewer*. (See "Benefit Overview" for the services that require prior approval.). If you receive these services from a *Tufts HP Spirit Provider*, that *Provider* is responsible for obtaining approval from an *Authorized Reviewer*. If you fail to obtain prior approval, the Spirit Plan will not cover those services and supplies.
- All claims are subject to retrospective review by an *Authorized Reviewer* to ensure that they are for the *Covered Services* described in Part 5. The *Plan* will only pay claims that are for *Covered Services*.

YOUR COSTS FOR *COVERED SERVICES*

For information about your costs (i.e., *Copayments*, *Coinsurance*, and *Deductibles*) for the *Covered Services* listed below, see the "Benefit Overview" starting on page 11. Information about the day, dollar, and visit limits under this plan can be found in the "Benefit Overview" and in certain *Covered Services* listed below.

Note: Italicized words are defined in Part 8.

Emergency Care

If you are experiencing an *Emergency*, you should seek care at the nearest *Emergency* facility. If needed, call 911 for emergency medical assistance. If 911 services are not available in your area, call the local number for emergency medical services.

If you receive *Emergency* services but are not admitted as an *Inpatient*, the services will be covered up to the *Reasonable Charge*. You will be required to pay a *Copayment*, then the *Deductible* for each *Emergency* room visit. *Emergency Covered Services* from a non-*Plan Provider* are subject to the applicable *Copayment* and *Deductible* (up to the *Reasonable Charge*). You will be responsible for any charges in excess of the *Reasonable Charge*. If you receive a bill for these services from a non-*Plan Provider*, please contact Member Services at 800-870-9488.

Notes:

- The *Emergency* room *Copayment* is waived if you are admitted as an *Inpatient*, or if the *Emergency* room visit results in an immediate *Day Surgery*. It may apply if you register in an *Emergen*cy room but leave without receiving care. The *Copayment* applies to *Observation* services. Call Member Services at 800-870-9488 for more information.
- If you are admitted as an *Inpatient* after receiving *Emergency* care, you or someone acting for you must notify *Tufts Health Plan* within 48 hour of seeking care to be covered. (Notification from the attending physician satisfies this requirement.)
- If you are admitted to an *Inpatient* mental health facility after being seen at the *Emergency* room, the *Emergency* room *Copayment* will be waived. *Members* must call the *Tufts Health Plan* Member Services Department to request this waiver or to have the claim adjusted.
- If you are admitted as an *Inpatient* to a hospital that is not a *Tufts HP Spirit Hospital* after receiving *Emergency* care, that admission will be subject to *Inpatient Copayment Tier 2* (a $700 *Copayment* per admission).

Outpatient Care

Autism spectrum disorders – diagnosis and treatment (prior approval from an *Authorized Reviewer* is required)

Autism spectrum disorders include any of the pervasive *Developmental* disorders, as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, and include autistic disorder, Asperger's disorder, and pervasive *development* disorders not otherwise specified.

Coverage is provided, in accordance with Massachusetts law, for the diagnosis and treatment of autism spectrum disorders. *Covered Services* include:

- *Habilitative* or rehabilitative care: professional, counseling and guidance services and treatment programs that are necessary to develop, maintain, and restore the functioning of the individual. These programs may include, but are not limited to, applied behavioral analysis (ABA) supervised by a Board-Certified Behavior Analyst. For the purposes of this benefit, ABA includes the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. Services provided by a paraprofessional or a Board-Certified Behavioral Analyst are covered as described under your "Mental Health, Substance Use Disorder, and Enrollee Assistance Programs" benefit (pages 96-115), administered by Beacon Health Options. Services provided by licensed or certified speech therapists, occupational therapists, physical therapists, or social workers (See "*Outpatient* medical care" and "Rehabilitative and *Habilitative* physical and occupational therapy services" on pages 46-47 and 49). Please note that benefit limits for physical and occupational therapy do not apply when these services are provided for the treatment of autism spectrum disorders.
- Prescription medications, (see "Prescription Drug Benefit" on pages 63-70
- Psychiatric and psychological care (see "Mental Health, Substance Use Disorder, and Enrollee Assistance Program" on pages 96-115)

Outpatient Care - continued

Cardiac rehabilitation
The *Plan* covers services for the *Outpatient* treatment of documented cardiovascular disease that:
(1) Meet the standards promulgated by the Massachusetts Commissioner of Public Health, and
(2) Are initiated within 26 weeks after diagnosis of cardiovascular disease.

The *Plan* covers only the following services:

- *Outpatient* convalescent phase of the rehabilitation program following hospital discharge
- *Outpatient* phase of the program that addresses multiple risk reduction, adjustment to illness and therapeutic exercise.

Notes:
- Once treatment has been initiated, the *Member* can receive covered cardiac rehabilitation services for up to 6 months from the date of the first visit.
- For *Members* with angina pectoris, only one course of cardiac rehabilitation services will qualify as *Covered Services*.
- The *Plan* does not cover the program phase that maintains rehabilitated cardiovascular health.

Chiropractic services (Spinal manipulation)

Spinal manipulation, when provided by a chiropractor.
Limit of one spinal manipulation evaluation and a total of 20 visits per *Member* in a *Contract Year*.

Note: Chiropractic services for *Members* age 12 and under are not covered.

Clinical trials studying potential treatment(s) for cancer or other life-threatening diseases or conditions
As required by applicable law, patient care services provided as part of a qualified clinical trial studying potential treatment(s) for cancer or other life-threatening diseases or conditions are covered to the same extent as those *Outpatient* services would be covered if the *Member* did not receive care in a qualified clinical trial.

Please see page 54 or call Member Services at 800-870-9488 for more information about the criteria for a qualified clinical trial.

Contraceptives – See “Family Planning Procedures, Services, and Contraceptives” on page 44.

Coronary Artery Disease Program
A Coronary Artery Disease secondary prevention program assists *Members* with documented Coronary Artery Disease in making necessary lifestyle changes to reduce your cardiac risk factors. This benefit is available, when *Medically Necessary*, at designated programs to *Members* who meet the clinical criteria established for this program.
For more information about this program, call Member Services at 800-870-9488.

Diabetes self-management training and educational services
Outpatient self-management training and educational services, including medical nutrition therapy, used to diagnose or treat insulin-dependent diabetes, non-insulin dependent diabetes, or gestational diabetes. Services must be provided by a *Tufts HP Spirit Provider* who is a certified diabetes health care provider.

Note: Medical nutritional therapy provided under this benefit is not subject to any visit limit described in the “Nutritional counseling” benefit on page 47.

Dialysis
Outpatient dialysis treatment, including hemodialysis and peritoneal dialysis, is covered. Home peritoneal dialysis is a *Covered Service*. Home hemodialysis is covered only when provided under the direction of a general or chronic disease hospital or free-standing dialysis facility.

***Outpatient* Care - continued**

Early intervention services for a *Dependent Child*
Early intervention services include occupational, physical and speech therapy, nursing care and psychological counseling.

These services must be provided by early intervention programs that meet the standards established by the Massachusetts Department of Public Health.

Services are available to *Members* from birth until their third birthday.

Family planning procedures, services, and contraceptives
Family planning services include medical examinations, birth control counseling, and genetic counseling. Covered family planning procedures include tubal ligation, sterilization, and pregnancy termination.

The following contraceptives are available, when provided by a physician and administered in that physician's office:

- Cervical caps
- Implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants)
- IUDs
- Depo-Provera or its generic equivalent

Note: *Tufts HP* covers certain contraceptives, such as oral contraceptives, over-the-counter female contraceptives, and diaphragms, under your Prescription Drug Benefit.

Outpatient Care - continued

Infertility services (may require prior approval from an *Authorized Reviewer*

Infertility occurs when a female *Member* has been unable to conceive or produce conception, during a period of: (1) one year if age 35 or younger, or (2) during a period of six months if over the age of 35. If a woman conceives but is unable to carry the pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy will be included in the calculation of the one-year or six-month period, as applicable.

Covered infertility services, which may require prior approval from an *Authorized Reviewer* (as noted by **(AR)**), include:

- Diagnostic procedures and tests
- Procurement, processing, and long-term (longer than 90 days) banking of sperm when associated with active infertility treatment.
- Artificial insemination (intrauterine or intracervical) **(AR)**
- Cryopreservation of eggs (less than 90 days) **(AR)**
- Procurement and processing of eggs or inseminated eggs or banking of inseminated eggs when associated with active infertility treatment **(AR)**
- I.V.F. (in-vitro fertilization and embryo transfer) **(AR)**
- D.O. (donor oocyte) **(AR)**
- F.E.T. (frozen embryo transfer) **(AR)**
- Z.I.F.T. (zygote intra-fallopian transfer) **(AR)**
- Assisted hatching **(AR)**
- G.I.F.T. (gamete intra-fallopian transfer) **(AR)**
- I.C.S.I. (intracytoplasmic sperm injection) **(AR)**

Donor sperm is only covered when the partner has a diagnosis of male factor infertility.

Oral and injectable drug therapies used in the treatment of infertility associated with the *Covered Services* below are covered only when the *Member* has been approved for associated infertility services. (See the "Prescription Drug Benefit" section for your *Copayment* amounts.)

Note: Artificial insemination and the ART procedures described above will only be considered *Covered Services* for *Members* with infertility who meet the eligibility criteria of *Tufts HP* (based on the *Member's* medical history and the *Plan's* contracted Infertility Services providers). Services must be approved in advance by an *Authorized Reviewer.* The procurement and processing of donor sperm, eggs, or inseminated eggs, or the banking of sperm or inseminated eggs, will be covered to the extent such costs are not covered by the donor's health care coverage, if any.

Outpatient Care – continued

Maternity Care

Covered Services include prenatal care, exams, and tests, and postpartum care provided in a physician's office.

Notes: You will be reimbursed for up to three visits with a lactation consultant per pregnancy. Please contact the *Tufts Health Plan* Member Services Department at 800-870-9488 for information about reimbursement for these services.

Maternity related tests (i.e., ultrasounds, diagnostic testing, and non-routine laboratory tests) are subject to the *Deductible.* However, in accordance with the ACA, routine laboratory tests associated with maternity care are covered in full and not subject to the *Deductible.* Please call Member Services for further information.

***Outpatient* medical care**

- Allergy testing (including antigens) and treatment, and allergy injections

  Note: Allergy treatment (for example, an allergy shot) is subject to an Office Visit *Copayment* when received as part of an office visit. However, there may not be a *Copayment* if the sole purpose of your visit is to receive allergy treatment (for example, an allergy shot).

- Chemotherapy. Please see "Injectable, inhaled or infused medications" later in this Part 5 for more information about coverage for medications.

- Diagnostic or preventive screening procedures (including, for example, colonoscopies, sigmoidoscopies, and proctosigmoidoscopies);

  Note: Please see page 17 of the "Benefit Overview" for information about your *Copayments* for these procedures.

- Diagnostic imaging, including:
  - General imaging (such as x-rays and ultrasounds)
  - MRI/MRA, CT/CTA, and PET tests and cardiology medicine **(may require prior approval from an *Authorized Reviewer*)**.
    Note: Please call Member Services at 800-870-9488 for more information about which services require prior authorization.

- Diagnostic testing including, **but not limited to**, sleep studies and diagnostic audiological testing. Prior approval by an *Authorized Reviewer* may be required. Please call Member Services at 800-870-9488 for questions about specific tests.

- EKG testing

- Human leukocyte antigen testing or histocompatibility locus antigen testing for use in bone marrow transplantation when necessary to establish a *Member's* bone marrow transplant donor suitability. Includes costs of testing for A, B or DR antigens; or any combination consistent with the rules and criteria established by the Department of Public Health

- Laboratory tests, including, but not limited to, blood tests, urinalysis, throat cultures, glycosolated hemoglobin (A1c) tests, genetic testing, and urinary protein/microalbumin and lipid profiles

  Note: Laboratory tests must be ordered by a licensed *Provider* and be performed at a licensed laboratory. Some laboratory tests (e.g., genetic testing) may require the approval of an *Authorized Reviewer.* In addition, please note that laboratory tests performed as part of preventive care are covered in full and not subject to the *Deductible.*

- Mammograms at the following intervals:
  - One baseline at 35-39 years of age
  - One every year at age 40 and older
  - As otherwise *Medically Necessary*

Outpatient Care – continued

Outpatient medical care *(continued)*

- Neuropsychological testing for a medical condition **(may require prior approval from an *Authorized Reviewer*)**

  Note: Neuropsychological testing for a mental health condition is **not** covered under the Medical and Prescription Drug Benefit section of your Spirit Plan and is not administered by *Tufts Health Plan*. For information about this testing, please refer to the "EAP/Mental Health and Substance Use Disorder Plan" section (pages 96-115) of this Member Handbook, which describes the benefits administered by Beacon Health Options.

- Nutritional counseling, including nutritional counseling for an eating disorder, when given outside of an approved home health care plan, prescribed by a physician, and performed by a registered dietician/nutritionist. Coverage is provided for one initial evaluation and a total of 3 treatment visits per *Contract Year*. Nutritional counseling visits are covered:
  - When *Medically Necessary,* for the purpose of treating an illness. Please see "Nutritional Counseling" in the "Benefit Overview" (Part 1) for the applicable *Cost Sharing Amount*; or
  - As preventive services, including preventive obesity screening and counseling services, healthy diet counseling, and behavior change counseling. In accordance with the Affordable Care Act, preventive services that are currently recommended by the U.S. Preventive Services Task Force (USPSTF) are covered in full.

  Notes: Weight loss programs and clinics are not covered.
  This visit limit does not apply to *Outpatient* nutritional counseling provided as part of:

  - An approved home health care plan (see "Home health care" benefit on page 55)
  - Treatment for an eating disorder
  - Diabetes self-management training and educational services (see benefit on page 42)

- Office visits to diagnose and treat illness or injury

  Note: This includes consultations, *Medically Necessary* evaluations and related health care services for acute or *Emergency* gynecological conditions, and visits to a *Limited Service Medical Clinic*.

- *Outpatient* surgery in a physician's office
- Pap Smears (cytology examinations) – one annual screening for women age 18 and older, or as otherwise *Medically Necessary*
- Radiation therapy and x-ray therapy
- Smoking cessation counseling services. These services may be provided through the QuitWorks program, or by physicians, nurse practitioners, physician assistants, nurse midwives, or *Tobacco Cessation Counselors*.

  This benefit includes individual, group, and telephonic smoking cessation counseling services that (1)are provided in accordance with current guidelines established by the United States Department of Health and Human Services; and (2) meet the requirements of the ACA.

  Note: Coverage is also provided for prescription and over-the-counter smoking cessation agents. For more information, see the "What is Covered" provision within the "Prescription Drug Benefit" section later in this chapter.

- Treatment of speech, hearing and language disorders (may require approval from an *Authorized Reviewer*). Services include speech therapy and short-term cognitive retraining or cognitive rehabilitation services, if provided to restore function lost or impaired as the result of an accidental injury or sickness.

  For these services to be covered, measurable improvement must be anticipated in a reasonable and predictable period of time for the particular diagnosis and phase of recovery

- Voluntary second or third surgical opinions

Outpatient Care – continued

Preventive health care – Adults (age 18 and over)
Preventive care services for *Members* age 18 and over include routine physical examinations, including appropriate immunizations and lab tests as recommended by the physician. They also include immunizations and lab tests, when not rendered as part of a routine physical exam.

Please visit **uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations** for more information about which services are considered preventive.

Note: Any *Medically Necessary* follow-up care resulting from a routine physical exam is subject to an *Office Visit Copayment,* as described under "Office visits to diagnose and treat illness or injury" (page 47). Diagnostic tests or diagnostic laboratory tests ordered as part of a routine physical exam are subject to the *Deductible*.

Preventive health care – *Children* (under age 18)
Preventive care services for *Children* from birth until age 18 include:

- Physical examination, including limited developmental testing with interpretation and report,
- History,
- Measurements,
- Sensory screening, including hearing exams and screenings;
- Neuropsychiatric evaluation
- Developmental screening and assessment at the following intervals:
  - Birth until age 6 months: 6 visits
  - Age 6 months until age 18 months: 6 visits
  - Age 18 months until age 3: 6 visits
  - Age 3 until age 18: 1 visit per *Contract Year*
- Hereditary and metabolic screening at birth
- Appropriate immunizations and tuberculin tests
- Hematocrit, hemoglobin, or other appropriate blood tests
- Urinalysis as recommended by the physician
- Newborn auditory screening tests, as required by state law

Please visit **uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations** for more information about which services are considered preventive.

Note: Any *Medically Necessary* follow-up care resulting from a routine physical exam is subject to an *Office Visit Copayment,* as described under "Office visits to diagnose and treat illness or injury" (page 47). Diagnostic tests or diagnostic laboratory tests ordered as part of a routine physical exam are subject to the *Deductible*.

Routine annual gynecological exams
Includes any follow-up obstetric or gynecological care determined to be *Medically Necessary* as a result of that exam.

Please visit **uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations** for more information about which services are considered preventive.

Note: Any *Medically Necessary* follow-up care resulting from a routine annual gynecological exam is subject to an *Office Visit Copayment,* as described under "Office visits to diagnose and treat illness or injury" (page 47). Diagnostic tests or diagnostic laboratory tests ordered as part of a routine annual gynecological exam are subject to the *Deductible*.

Outpatient **Care – continued**

Rehabilitative and *Habilitative* physical and occupational therapy services (may require prior approval from an *Authorized Reviewer*)

Rehabilitative and *Habilitative* physical and occupational therapy services, including cognitive rehabilitation or cognitive retraining, are covered for up to 30 visits for each type of therapy per *Contract Year*.
Rehabilitative therapy services are covered only when provided to restore function lost or impaired as the result of an accidental injury or sickness. For rehabilitative therapy services to be covered, *Tufts Health Plan* must determine that the *Member's* condition is subject to significant improvement as a direct result of these therapies.

Habilitative physical and occupational therapy services are covered only when provided to keep, learn, or improve skills and functioning for daily living never learned or acquired due to a disabling condition.

Notes: Benefit limits do not apply when these services are provided for the treatment of autism spectrum disorders.

Massage therapy may be covered as a treatment modality only when administered as part of a physical therapy visit that is provided by a licensed physical therapist; and incompliance with *Tufts Health Plan's Medical Necessity* and (if applicable) prior authorization guidelines.

Urgent Care **in an *Urgent Care Center***

Urgent Care refers to services provided when your health is not in serious danger, but you need immediate medical attention for an unforeseen illness or injury. To find an *Urgent Care Center* (a medical facility, clinic, or medical practitioner's office) in *Tufts Health Plan's* network, please visit **tuftshealthplan.com** and click on "Find a Doctor".

Note: Care that is rendered after the *Urgent* condition has been treated and stabilized and the *Member* is safe for transport is not considered *Urgent Care*.

Vision Care Services

Covered vision care services include:

- Routine eye exams (one exam in each 24-month period). Exams must be received from a *Provider* in the EyeMed Vision Care network in order to be covered. Please go to **tuftshealthplan.com** or contact Member Services at 800-870-9488 for more information.
- Eye examinations and necessary treatment of a medical condition

Oral health services (may require prior approval from an *Authorized Reviewer*)

***Emergency* Dental Care**

Benefits are provided for treatment rendered by a dentist within 72 hours of an accidental external injury to the mouth and sound natural teeth. This treatment is limited to initial first aid (trauma care), reduction of swelling, pain relief, covered non-dental surgery and non-dental diagnostic x-rays.

Note: Repair or restoration of teeth is not a *Covered Service*.

Oral Surgery for Dental Treatment in an *Inpatient* or *Day Surgery* setting

Benefits are provided only if the *Member* is of young age and/or (2) has a serious medical condition (including, but not limited to, hemophilia and heart disease) that makes it essential that he or she be admitted to a general hospital as an *Inpatient* or to a *Day Surgery* unit or ambulatory surgical facility for the dental care to be performed safely. Covered procedures in an *Inpatient* or *Day Surgery* setting include:

- Extraction of seven or more permanent, sound natural teeth
- Gingivectomies (including osseous surgery) of two or more gum quadrants
- Excision of radicular cysts involving the roots of three or more teeth
- Removal of one or more bone impacted teeth.

Note: The above services are not covered when performed in an office setting.

Oral surgical procedures for non-dental medical treatment

Oral surgical procedures for non-dental medical treatment (i.e., the reduction of a dislocated or fractured jaw or facial bone, surgical treatment of cleft lip or cleft palate for *Children* under the age of 18, and removal or excision of benign or malignant tumors) are covered to the same extent as are other covered surgical procedures.

Day Surgery **(may require prior approval from an *Authorized Reviewer*)**

Covered *Day Surgery* services include *Outpatient* surgery done under anesthesia in an operating room of a facility licensed to perform surgery, and associated physician and surgeon services. You must be expected to be discharged the same day and be shown on the facility's census as an *Outpatient*.

Note: If you are admitted to a *Tufts HP Spirit Hospital* immediately following *Day Surgery,* the *Day Surgery Copayment* will be waived. You will instead be required to pay the applicable *Inpatient Copayment* for that hospital admission. Call Member Services at 800-870-9488 for more information.

***Inpatient* care**

Important Note: *Members* will only be responsible for one *Inpatient Copayment* if readmitted within 30 days of discharge. Please call Member Services to arrange to have the second *Copayment* waived.

Acute hospital services

- Semi-private room (private room when *Medically Necessary*)
- Physician and surgeon services while hospitalized
- Surgery **(AR)**
- Anesthesia
- Nursing care
- Intensive care/coronary care
- Diagnostic tests, imaging, and lab services
- Radiation therapy
- Dialysis
- Physical, occupational, speech, and respiratory therapies
- *Durable Medical Equipment* and appliances
- Drugs.

Note: Prior approval by an *Authorized Reviewer* is required for surgery services.

Bone Marrow Transplants for Breast Cancer, Hematopoietic Stem Cell Transplants, and Human Solid Organ Transplants (requires prior approval from an *Authorized Reviewer*)
Bone marrow transplants for *Members* diagnosed with metastatic breast cancer who meet the criteria established by the Massachusetts Department of Public Health are *Covered Services*

Covered Services also include hematopoietic stem cell transplants and human solid organ transplants. The *Plan* pays for charges incurred by the donor in donating the organ to the *Member*, but only to the extent that charges are not covered by any other health insurer. This includes evaluation and preparation of the donor, surgery, and recovery services when those services relate directly to donating the organ to the *Member*.

Notes:

- The *Plan* **covers** a *Member's* human leukocyte antigen testing (HLA) testing. See page 46 in "*Outpatient* care" for more information.
- The *Plan* **does not cover** the following services related to bone marrow and human organ transplants:
  - Transportation costs for the donated stem cells or solid organs
  - Donor charges for *Members* who donate stem cells or solid organs to non-*Members*
  - Search costs for matching or for laboratory testing, either (1) to identify a donor for a recipient who is a *Member,* or (2) for a *Member* being considered as a potential stem cell or solid organ donor (whether or not the recipient is a *Member*)

Inpatient care, continued

Gender reassignment surgery and related services
Coverage is provided for gender reassignment surgery and related pre- and post-operative services and prescription drugs. Mental health care services for *Members* undergoing the gender reassignment process are covered through Beacon Health Options. (See the "Mental Health, Substance Use Disorder, and Enrollee Assistance Program" section (page 96-115) for more information.)

Covered Services offered through *Tufts HP* include:

- *Inpatient* services, including female to male or male to female gender reassignment surgery and related surgical procedures
- *Day Surgery* for surgical procedures related to the female to male or male to female gender reassignment surgery. These services are covered as described under "*Day Surgery*" earlier in this Part 5.
- *Outpatient* medical care (pre-operative and post-operative) related to gender reassignment surgery. These services are covered as described under "Office visits to diagnose and treat illness or injury", earlier in this Part 5.
- Prescription medications required as part of the gender reassignment process. These medications are covered as described under the "Prescription Drug Benefit", later in this Part 5.

Note: Services must be authorized in advance by an *Authorized Reviewer.* *Members* must meet specific *Medical Necessity* Guidelines in order for these services to be covered. Gender reassignment surgery and related services only qualify as *Covered Services* when they are obtained within the 50 United States. Please call Member Services at 800-970-9488 for more information.

Inpatient care, continued

Maternity Care
The following *Covered Services* are available to a mother and her newborn *Child*, regardless of whether or not there is an early discharge (less than 48 hours following a vaginal delivery or 96 hours following a caesarean delivery):

- Hospital and delivery services
- Newborn hearing screening test
- Well newborn *Child* care in hospital
- *Inpatient* care in hospital for mother and newborn *Child* for at least 48 hours following a vaginal delivery and 96 hours following a caesarean delivery
- One home visit by a registered nurse, physician, or certified nurse midwife, and additional home visits by a licensed health care *Provider*, when *Medically Necessary*
- Parent education, assistance, and training in breast and bottle feeding
- The performance of any necessary and appropriate clinical tests

Benefits for Newborn *Children* at Time of Delivery

Massachusetts law requires a newborn *Child's Routine Nursery Care* to be covered under the maternity coverage benefits of the mother's health plan. If the mother is not a *Member* under the *Plan* and has no other maternity coverage benefits, the *Plan* will cover *Medically Necessary* care that the newborn *Child* may require (either *Routine Nursery Care* or other care) if that newborn *Child* is enrolled in the *Plan.*

The *Plan* will pay for *Medically Necessary* care as follows:

IF the mother is…	**AND the newborn *Child* is…**	**THEN the *Plan* covers…**
A ***Member*** whose delivery was performed by a *Tufts HP Spirit Provider*	Enrolled	*Routine Nursery Care* and other *Medically Necessary* care from a *Tufts HP Spirit Provider*
	Not enrolled	*Routine Nursery Care* only
Not a *Member* under the *Plan* and has **no other maternity coverage benefits**	Enrolled (e.g., by the other parent, who is a *Subscriber*)	*Routine Nursery Care* and other *Medically Necessary* care from a *Tufts HP Spirit Provider*
	Not enrolled	Not covered

See Part 4 for information about enrolling a newborn *Child* in the *Plan.*

Inpatient **care, continued**

Patient care services provided as part of a qualified clinical trial studying potential treatment(s) for cancer or other life-threatening diseases or conditions
As required by applicable law, the *Plan* covers patient care services provided as part of a qualified clinical trial studying potential treatment(s) for cancer or other life-threatening diseases or conditions. Patient care services include items and services provided when you are enrolled in a qualified clinical trial consistent with your diagnosis and the study protocol. Coverage is subject to all pertinent provisions of the *Plan*, including, but not limited to, use of *Tufts HP Providers*, utilization review and provider payment methods.

The following services are covered under this benefit:

(1) All *Medically Necessary* services for treatment of your condition, consistent with the study protocol of the clinical trial, and for which coverage is otherwise available under the *Plan*.
(2) The allowed cost, as determined by the *Plan*, of investigational drugs or devices appropriate for use in the qualified clinical trial if they are not paid for by its manufacturer, distributor, or provider. This is true regardless of whether the Food and Drug Administration has approved the drug or device for use in treating the patient's particular condition.

"Patient care services" do not include any of the following:

1. Investigational drugs or devices that do not meet the criteria in (2) above.
2. Non-health care services that a patient may be required to receive as a result of participation in the clinical trial
3. Costs associated with managing the research of the clinical trial
4. Costs that would not be covered for non-investigational treatments
5. Any items, services or costs that are reimbursed or provided by the sponsor of the clinical trial
6. Services that are inconsistent with widely accepted and established national or regional standards of care
7. Services that are provided primarily to meet the needs of the trial, including, but not limited to, tests, measurements and other services that are typically covered but are being provided at a greater frequency, intensity or duration under the clinical trial
8. Services or costs that are not covered under the *Plan*

***Inpatient* care, continued**

Reconstructive surgery and procedures (may require prior approval from an *Authorized Reviewer*)

- Services required to repair or restore a bodily function that is impaired as a result of a congenital defect (including treatment of cleft lip or cleft palate for *Children* under the age of 18), birth abnormality, traumatic injury, or covered surgical procedure **(AR)**
- The following services in connection with mastectomy:
  - Reconstruction of the breast affected by the mastectomy
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance
  - Prostheses (covered as described under "Medical Appliances and Equipment" on page 59) and treatment of physical complications of all stages of mastectomy
  - Removal of breast implants when there is documented rupture of a silicone implant, auto-immune disease or infection **(AR)**

Notes: *Cosmetic* Surgery is not covered. No coverage is provided for the removal of ruptured or intact saline breast implants or intact silicone breast implants except as specified above.

Other Health Services

Ambulance services (may require prior approval from an *Authorized Reviewer*)
The following ambulance services are *Covered Services*.

- Ground, sea, and helicopter ambulance transportation for *Emergency* care.
- Airplane ambulance services (e.g., Medflight) **(AR)**
- Non-emergency, *Medically Necessary* ambulance transportation between covered facilities **(AR)**
- Non-emergency ambulance transportation for *Medically Necessary* care when the *Member's* medical condition prevents safe transportation by any other means **(AR)**

Notes: Please note that the *Plan* does not cover transportation by chair car or wheelchair van. If you are treated by Emergency Medical Technicians (EMTs) or other ambulance staff but refuse to be transported to the hospital or other medical facility, you may be responsible for the costs of this treatment.

Cleft lip or cleft palate treatment and services for *Children* under 18

The following *Covered Services* must be prescribed by the treating physician or surgeon, who must certify that the services are *Medically Necessary* and are required because of the cleft lip or cleft palate:

- **Medical and facial surgery:** Covered as described under "*Day Surgery*", "Acute hospital services", and "Reconstructive surgery and procedures" earlier in this chapter. This includes surgical management and follow-up care by plastic surgeons.
- **Oral surgery:** Covered as described under "Oral surgical procedures for non-dental medical treatment" in the "Oral Health Services" benefit earlier in this chapter. This includes surgical management and follow-up care by oral surgeons.
- **Dental surgery or orthodontic treatment and management**;
- **Preventive and restorative dentistry** to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy;
- **Speech therapy and audiology services:** Covered as described under "Treatment of speech, hearing and language disorders" earlier in this chapter.
- **Nutrition services:** Covered as described under "Nutritional counseling" earlier in this chapter.

Extended Care (requires prior approval from an *Authorized Reviewer*)
The *Plan* covers the following *Covered Services* in an extended care facility (skilled nursing facility, rehabilitation hospital, or chronic hospital) for:

- Skilled nursing services (limit of 45 days per *Member* in a *Contract Year*)
- Chronic disease services
- Rehabilitative services

Other Health Services – continued

Home health care
(requires prior approval from an *Authorized Reviewer*)

The *Plan* covers the following services provided, under a physician's written order, by an accredited home health agency to homebound* *Members*:

- Home visits by a *Tufts HP Spirit* physician
- Skilled nursing care and physical therapy
- The following services, if determined to be a *Medically Necessary* component of skilled nursing or physical therapy:
    - Speech therapy
    - Occupational therapy
    - Medical/psychiatric social work
    - Nutritional consultation
    - *Durable Medical Equipment* (see "Medical Appliances and Equipment" on page 59)
    - The services of a part-time home health aide

*To be considered homebound, you do not have to be bedridden. However, you must usually be unable to leave the home without a considerable and taxing effort. You may be considered homebound if your absences from the home are infrequent, for periods of relatively short duration, or to receive medical treatment.

Note: Home health care services for physical and occupational therapies following an injury or illness are covered only if provided to restore lost or impaired function, as described under "Rehabilitative and *Habilitative* physical and occupational therapy services" on page 49. However, those home health care services are not subject to the 30-visit limit.

Hospice and End-of-Life care services
Hospice provides multidisciplinary care designed to address the physical, social, emotional and spiritual needs of persons likely to live 6 months or less. Hospice care has may benefits: better quality of life, better coping for you and your family, and longer survival time at home.

The *Plan* will cover the following hospice care services when a physician certifies or (re-certifies) that you have a medical prognosis of 6 months or less to live:

- Physician services
- Nursing care provided by or supervised by a registered professional nurse
- Social work services
- Volunteer services
- Counseling services (including bereavement counseling services for the *Member's* family or a primary care person for up to one year following the *Member's* death).
- Concurrent palliative chemotherapy and radiation therapy, if palliative, are permitted.

"Hospice care services" are a coordinated licensed program of services provided to *Members* with six months or less to live. Such services can be provided at home; on an *Outpatient* basis, and on a short-term *Inpatient* basis, to control pain and manage acute and severe clinical problems that cannot medically be managed at home.

If you have a medical prognosis of greater than six months to live, but you have symptoms like severe pain or difficulty breathing, the *Plan* covers palliative care services. Palliative care is focused on relieving pain or other symptoms of illness and improving the quality of life for patients and their families.

Other Health Services – continued

Injectable, infused or inhaled medications (may require prior approval from an *Authorized Reviewer*)

The *Plan* covers injectable, infused or inhaled medications that are: (1) required for and are an essential part of an office visit to diagnose or treat illness or injury; or (2) administered at home by a home infusion *Provider*. Medications include, but are not limited to, total parenteral nutrition therapy, chemotherapy, and antibiotics.

Notes:

- Quantity limits may apply.
- The *Plan* has designated home infusion *Providers* for a select number of specialty pharmacy products and drug administration services, including, but not limited to, medications used to treat hemophilia, pulmonary arterial hypertension, immune deficiency, and enzyme replacement therapy. These *Providers* offer clinical drug therapy management, nursing support, and care coordination to *Members* with acute and chronic conditions. Please contact Member Services or visit **tuftshealthplan.com** for more information.
- Coverage includes the components required to administer these medications, including, but not limited to, hypodermic needles and syringes, *Durable Medical Equipment*, supplies, pharmacy compounding, and delivery of drugs and supplies.
- Some injectable, infused, or inhaled medications may be covered under your *Tufts HP* pharmacy benefit. These medications, which are listed on the *Tufts HP* website as covered under the pharmacy benefit, are not covered under the "Injectable, infused or inhaled medications" benefit. For more information, call Member Services at 800-870-9488 or visit **tuftshealthplan.com/gic**.

Other Health Services – continued

Medical Appliances and Equipment

(1) *Durable Medical Equipment*

Durable Medical Equipment includes devices or instruments of a durable nature that are:

- Reasonable and necessary to sustain a minimum threshold of independent daily living
- Made primarily to serve a medical purpose
- Not useful in the absence of illness or injury
- Able to withstand repeated use
- Intended to be used in the home.

Please call Member Services at 800-870-9488 if you need *Durable Medical Equipment*. *Tufts Health Plan* will decide whether to purchase or rent the equipment for you. This equipment must be purchased or rented from a *Durable Medical Equipment Provider* that has an agreement with *Tufts Health Plan.*

To be eligible for coverage, the equipment must be the most appropriate available amount, supply or level of service for the *Member,* considering the potential benefits and harms to that individual.

Equipment that *Tufts Health Plan* determines to be non-medical in nature and used primarily for non-medical purposes (even though it may have some limited medical use) will not be considered *Durable Medical Equipment* and will not be covered under this benefit.

Examples of covered items (list is not all–inclusive). Please call Member Services at 800-870-9488 with questions about whether a particular piece of equipment is covered:

- *Prosthetic Devices* (such as artificial legs, arms, eyes, or breasts) **(may require prior approval from an *Authorized Reviewer*)**
    - Breast prostheses provided in connection with a mastectomy do not require prior approval from an *Authorized Reviewer*.
    - Coverage for breast prostheses and prosthetic arms and legs (in whole or in part) is provided for the most appropriate *Medically Necessary* model, and includes coverage for the cost of repairs.
- Purchase of a manual or electric (non-hospital grade) breast pump, or the rental of a hospital grade electric breast pump for pregnant or post-partum *Members* (when prescribed by a *Provider*) (**Note:** Breast pumps are covered in full.)
- Gradient stockings (up to three pairs per *Contract Year*)
- Devices that extract oxygen from the air (for example, stationary and portable oxygen concentrators)
- Orthotic devices (such as knee and back braces)
- Blood glucose monitors, including voice synthesizers for blood glucose monitors for use by the legally blind
- Insulin pumps
- Oral appliances for the treatment of sleep apnea
- Hospital beds, wheelchairs, power/electric wheelchairs, crutches, and walkers

Examples of excluded items (list is not all-inclusive):

- Articles of special clothing, except for gradient pressure support aids for lymphedema or venous disease and clothing necessary to wear a covered device (e.g., mastectomy bras and stump socks)
- Bed-related items, including, but not limited to, bed cradles, bed trays, bed pans, over-the-bed tables, and bed wedges
- Car/van modifications
- Comfort or convenience devices, including, but not limited to, air conditioners, air purifiers, and dehumidifiers
- Dentures
- Exercise equipment
- Fixtures to real property (e.g., ceiling lifts, elevators, ramps, or stair climbers)
- Foot orthotics and arch supports, except for therapeutic/molded shoes and shoe inserts for *Members* with severe diabetic foot disease

Other Health Services – continued

Medical Appliances and Equipment, continued

Examples of excluded items, continued (list is not all-inclusive):

- Heating pads
- Home blood pressure apparatus (manual) with cuff and stethoscope
- Hot tubs, jacuzzis, shower chairs, swimming pools, or whirlpools
- Hot water bottles
- Mattresses, except for mattresses used in conjunction with a hospital bed and ordered by a physician. Commercially available standard mattresses (e.g., Tempur-Pedic® or Posturepedic® mattresses), even if used in conjunction with a hospital bed, are not covered.
- Saunas
- Self-monitoring devices, except for certain devices that *Tufts Health Plan* determines would provide a *Member* with the ability to detect or prevent the onset of a sudden life-threatening condition
- Thermal therapy devices
- Wheelchair trays

(2) Other Medical Appliances and Equipment

- The first pair of eyeglass lenses (frames are not covered or contact lenses following cataract surgery
- Contact lenses, including the fitting of the lenses, when required to treat keratoconus
- Hearing aids, including the fitting of the hearing aid, are covered when prescribed by a physician and obtained from a hearing aid supplier.
  - *Children* 21 and under: the *Plan* provides full coverage for hearing aid evaluations, the fitting and adjusting of hearing aids, and supplies (including ear molds) for one hearing aid per ear per prescription change. Limit of $2,000 per ear every 36 months.
  - *Members* 22 and over: the *Plan* covers the first $500 in full and 80% of the next $1,500, up toa limit of $1,700 per *Member* every 24 months. The *Member* is responsible for paying 20% of charges from $500-$2,000 (plus any balance).

When there is a pathological change in the *Member's* hearing or the hearing aid is lost, benefits for a replacement hearing aid are also covered subject to the benefit limit.

Note: Over-the-counter replacement hearing aid batteries are not covered.

Other Health Services – continued

Personal Emergency Response Systems (PERS)

Covered Services are provided only for installation and rental charges for a hospital-based Personal Emergency Response System when:

- The system is used as an alternative to reduce or divert *Inpatient* admissions.
- The *Member* is homebound and medically at risk, as determined by *Tufts Health Plan*.
- The *Member* is alone for at least four (4) hours each day, five (5) days a week and is functionally impaired.

Covered Services do not include the purchase of a Personal Emergency Response System.

Note: Covered PERS benefits are limited to a total of $50 per *Member* for installation charges and $40 per *Member* each month for rental of the system. The Spirit Plan pays 80% of the charges up to the limit for allowed installation and rental charges. You are responsible for paying the remaining 20% of those charges, as well as any additional fees or charges for the system.

Private Duty Nursing

Inpatient private duty nursing services qualify as *Covered Services* when:

- The *Member* is a Hospital *Inpatient* for the treatment of a medical condition.
- The health care facility's regular nursing staff could not perform the services, due to the frequency and complexity of the skilled nursing care
- The services are *Medically Necessary*, as determined by *Tufts Health Plan*.

Private duty nursing services provided in the *Member's* home qualify as *Covered Services* when:

- The administration of treatment and the evaluation of the patient's response to the treatment require the skills of a registered nurse, due to the frequency and complexity of the skilled nursing care
- The services are *Medically Necessary*, as determined by *Tufts Health Plan*
- The services are approved by an *Authorized Reviewer*

Note: Covered private duty nursing services (whether as an *Inpatient,* at home, or both) are limited to a total of $8,000 per *Member* in a *Contract Year*.

Scalp Hair Prostheses or Wigs

Covered Services include scalp hair prostheses or wigs worn for hair loss due to (1) alopecia areata, alopecia totalis, or permanent loss of scalp hair due to injury, or (2) the treatment of any form of cancer or leukemia.

Other Health Services -- continued

Special medical formulas

This includes special medical formulas, nonprescription enteral formulas, and low protein food when prescribed by a physician to treat the below conditions:

- Special Medical Formulas (may require prior approval from an *Authorized Reviewer*)
  - Phenylketonuria (including formulas to protect the fetus of a woman with PKU, when *Medically Necessary*
  - Tyrosinemia
  - Homocystinuria
  - Maple syrup urine disease
  - Propionic acidemia
  - Methylmaloric acidemia
- Low Protein Foods, when given to treat inherited diseases of amino acids and organic acids
- Nonprescription enteral formulas (may require prior approval from an *Authorized Reviewer*)
  - Malabsorption caused by Crohn's disease
  - Ulcerative colitis
  - Gastroesophageal reflux
  - Gastrointestinal motility
  - Chronic intestinal pseudo-obstruction
  - Inherited diseases of amino acids and organic acids
  - *Medically Necessary* formulas, including infant formula for milk or soy protein intolerance; formula for premature infants; and supplemental formulas for growth failure

Prescription Drug Benefit

Introduction

This section describes the prescription drug benefit. The following topics are included in this section to explain your prescription drug coverage:

- How Prescription Drugs Are Covered
- Prescription Drug Coverage Table
- What is Covered
- What is Not Covered
- *Tufts HP* Pharmacy Management Programs
- Filling Your Prescription

How Prescription Drugs Are Covered

Prescription drugs will be considered *Covered Services* only if they comply with the *Tufts Health Plan* Pharmacy Management Programs section described below and are:

- Listed below under *What is Covered*;
- Approved by the United States Food and Drug Administration (FDA);
- Provided to treat an injury, illness, or pregnancy;
- Written by a *Tufts Health Plan Spirit Provider*, except in cases of authorized referral or in *Emergencies;* and
- *Medically Necessary*.

For a current list of covered drugs, as well as a list of non-covered drugs, please visit **tuftshealthplan.com**, or call the Member Services Department at 800-870-9488.

Prescription Drug Benefit, continued

Prescription Drug *Deductible*
A $100 individual Prescription Drug *Deductible* and a $200 family Prescription Drug *Deductible* apply each *Contract Year*. Your family Prescription Drug *Deductible* is met once any combination of family *Members* reaches $200; no family *Member* will pay more than his or her individual Prescription Drug *Deductible* per *Contract Year*.

The Prescription Drug *Deductible* is the amount you must first pay for covered prescription drugs before the *Spirit Plan* will pay for any covered prescription drugs. The amount you accrue towards your *Deductible* when filling a prescription is calculated based *Tufts Health Plan's* contracted rate at the time the prescription is filled and does not reflect any rebates that we may receive at a later date.

This Prescription Drug *Deductible* does **not** apply to smoking cessation agents or to generic buprenorphine-naloxone, naloxone, and naltrexone products.

Note: *Copayments* do not apply until you have met the Prescription Drug *Deductible*.

PRESCRIPTION DRUG COVERAGE TABLE*	
Description	**Coverage**
DRUG OBTAINED AT AT A RETAIL PHARMACY Up to a 30-day supply of covered prescription drugs	**Tier 1 drugs:** $10 *Copayment* **Tier 2 drugs:** $30 *Copayment* **Tier 3 drugs:** $65 *Copayment*
DRUGS OBTAINED THROUGH THE TUFTS HP DESIGNATED SPECIALTY PHARMACY Up to a 30-day supply of covered specialty drugs	**Tier 1 drugs:** $10 *Copayment* **Tier 2 drugs:** $30 *Copayment* **Tier 3 drugs:** $65 *Copayment*
MAINTENANCE MEDICATIONS OBTAINED AT A CVS PHARMACY OR THROUGH THE TUFTS HP DESIGNATED MAIL SERVICES PHARMACY Up to a 90-day supply of most maintenance medications	**Tier 1 drugs:** $25 *Copayment* **Tier 2 drugs:** $75 *Copayment* **Tier 3 drugs:** $165 *Copayment*

***If the retail cost of your prescription is less than your *Copayment*, then you are only responsible for the actual retail cost.**

Notes:

- Tier 1 includes may generic drugs. However, generic drugs may be placed on any of the three tiers. Generic versions of drugs that are priced significantly lower than the brand-name version of the drug are usually placed on Tier 1. However, in situations where the generic price remains very close to the brand-name price, the generic may be placed on Tier 2. In addition, generic drugs that are both high-cost and offer no clinical advantage over other generics in the therapeutic category may be placed on Tier 3.
- In Massachusetts, and in many other states, when your physician prescribes a brand-name drug that has a generic equivalent, you will receive the generic drug and pay the applicable Tier *Copayment.* However, regardless of where you fill your prescription, if your physician requests that you receive the covered brand-name drug only, you will pay the *Copayment* applicable to the generic drug plus the difference between the cost of the generic drug and the cost of the covered brand-name drug. In most cases, there may be a significant difference in price between the brand-name drug and the generic drug, resulting in a significant difference in what you are required to pay.

(continued on next page)

Prescription Drug Benefit, continued

PRESCRIPTION DRUG COVERAGE, continued

Notes, continued:

- The *Plan* has set up a program for maintenance medications, called the "Maintenance Choice" program. This program is described in more detail on page 68.
- Under the Affordable Care Act oral contraceptives, diaphragms, and other hormonal contraceptives that by law require a prescription, and FDA-approved over-the counter female contraceptives prescribed by a licensed *Provider* and dispensed at a pharmacy pursuant to a prescription, are covered in full.
- Oral fluoride for *Children* under age 6 and folic acid for women between the ages of 13 and 44 are covered in full, as required by the ACA.
- Prescription and generic over-the-counter smoking cessation agents are covered in full, as required by the ACA.
- Orally administered anticancer medications are covered in full. These medications are not subject to any prescription drug deductible.
- Certain medications used for bowel preparation in colonoscopy procedures are covered in full. This applies to *Members* aged 50 through 74. For more information, please call Member Services or see the formulary at **tuftshealthplan.com**.
- Generic buprenorphine-naloxone, naloxone, and naltrexone products are covered in full, and are not subject to the Prescription Drug *Deductible*. Prior authorization is not required for these drugs.
- Certain drugs on our formulary are designated as part of our low cost drug program. Your retail pharmacy *Copayments* for these low cost drugs are $5 for up to a 30-day supply and $10 for a 31-90 day supply. Please visit **tuftshealthplan.com/member/pharmacy/commercial-plans-pharmacy** or call Member Services for more information.

Prescription Drug Benefit, continued

What is Covered under this Prescription Drug Benefit

The Spirit Plan covers the following under this Prescription Drug Benefit:

- Prescribed drugs that by law require a prescription and are not listed under "What is Not Covered" (below)
- Hormone replacement therapy for peri- and post-menopausal women
- Diabetes supplies, including insulin, insulin pens, and insulin needles and syringes; oral diabetes medications (hypoglycemics); and urine glucose and ketone monitoring strips
- Oral contraceptives, diaphragms, and other hormonal contraceptives (e.g., patches, rings) that require a prescription and that are not mandated benefits under the Affordable Care Act

  Note: See "Family planning procedures, services and contraceptives" on page 44 of this Spirit *Member Handbook* for information about other contraceptive drugs and devices that qualify as *Covered Services* under the Affordable Care Act.
- Fluoride for *Children*
- Injectables and biological serum, except as covered under "Injectable, infused or inhaled medications" on page 58. *Medically Necessary* hypodermic needles and syringes required to inject these medications are also covered.
- Prefilled sodium chloride for inhalation (both prescription and over-the-counter with a prescription)
- Off-label use of FDA-approved prescription drugs to treat cancer or HIV/AIDS provided at least one of the following recognizes the drug for such treatment:
  - One of the standard reference compendia;
  - The medical literature; or
  - The Massachusetts Commissioner of Insurance.
- Compounded medications, if, by law, at least one active ingredient requires a prescription by law
- Prescription and over-the-counter (with a prescription) smoking cessation agents
- Over-the-counter drugs included in the list of covered drugs on the *Tufts HP* website when prescribed by a *Provider*. Please call Member Services for more information.

  Note: Certain prescription drug products may be subject to one of the **Pharmacy Management Programs** described below.

Prescription Drug Benefit, Continued

What is Not Covered
The Spirit Plan does not cover the following under this Prescription Drug Benefit*:

- Homeopathic medications
- Drugs that, by law, do not require a prescription (unless listed as covered in the "What is Covered' section above)
- Drugs that are not listed on the "Tufts Health Plan Prescription Drug List" at **tuftshealthplan.com.**
  - For additional information, see "Pharmacy Management Programs" and "Notes" later in this chapter, or call Member Services at 800-870-9488.
- Vitamins and dietary supplements (except prescription prenatal vitamins, vitamins as required by the Affordable Care Act, and fluoride for *Children*).
- Topical and oral fluorides for adults.
- Medications for the treatment for idiopathic short stature.
- *Experimental* drugs.
- Prescriptions written by physicians who do not participate in the *Plan*, except in cases of authorized referral or *Emergency* care.
- Prescriptions filled at pharmacies other than *Tufts Health Plan* designated pharmacies, except for *Emergency* care.
- Drugs for asymptomatic onchomycosis, except for *Members* with diabetes, vascular compromise, or immune deficiency.
- Acne medications, unless *Medically Necessary*.
- Drugs dispensed in an amount or dosage that exceeds *Tufts Health Plan's* established quantity limitations.
- Compounded medications, if no active ingredients require a prescription.
  - Some exceptions may apply. For more information, call Member Services or check our Web site at **tuftshealthplan.com**.
- Prescriptions filled through an internet pharmacy, unless it is a Verified Internet Pharmacy Practice Site certified by the National Association of Boards of Pharmacy.
- Prescription medications that are available over-the-counter
  - Both the specific medication and the entire class of prescription medications may not be covered.
- Prescription medications when packaged with non-prescription products.
- Over-the-counter medications if not included on the list of covered drugs on the *Tufts HP* website.
- Drugs classified as Schedule I controlled substances by the FDA (e.g., marijuana).
- Prescription medication when therapeutically equivalent medications with the same active ingredient (or a modified version of an active ingredient) are available over-the-counter
  - Both the specific medication and the entire class of prescription medications may not be covered.
  - Excluded medications include, but are not limited to: topical acne medications with benzoyl peroxide ≤ 10%; H_2 blockers with nizatidine, famotidine, cimetidine, or ranitidine; and oral non-sedating antihistamines. For a complete list of these excluded medications, visit **tuftshealthplan.com** or call Member Services at 800-870-9488.

Note: Certain drugs and products are not covered under your prescription drug benefit but may be covered elsewhere under the *Plan*. These services include:
- Cervical caps, IUDs, implantable contraceptives (e.g., Implanon ® (etonorgestrel), levonorgestrel implants), Depo-Provera (may be provided under your *Outpatient* care benefit – see "Family planning procedures, services, and contraceptives" on page 44
- Non-drug products such as therapeutic or other prosthetic devices, appliances, supports, or other non-medical products (may be provided as described in "Medical Appliances and Equipment" on page 59)
- Immunization agents (may be provided under *Preventive* health care on page 48)

***Tufts Health Plan* Pharmacy Management Programs**

In order to provide safe, clinically appropriate, cost-effective medications under this Prescription Drug Benefit, *Tufts Health Plan* has developed the following Pharmacy Management Programs:

- **Quantity Limitations Program -** *Tufts Health Plan* limits the quantity of selected medications that *Members* can receive in a given time period, for cost, safety and/or clinical reasons.

- **Prior Authorization Program -** *Tufts Health Plan* restricts the coverage of certain drug products that have a narrow indication for usage, may have safety concerns and/or are extremely expensive, requiring the prescribing physician to obtain prior approval from *Tufts Health Plan* for such drugs.
  - **Step Therapy PA Program –** Step therapy is an automated form of prior authorization which uses previous claims history for approval at the pharmacy. Step therapy programs help encourage the use of clinically proven appropriate, cost-effective therapies first, before other, possibly more expensive treatments may be covered.

- **Designated Specialty Pharmacy Program -** *Members* must obtain some medications from Caremark Specialty Pharmacy, which specializes in providing specific medications for treatment of complex diseases and offers clinical support services from nurses. Caremark Specialty Pharmacy can dispense up to a 30-day supply of medication at one time, and delivers them directly to the *Member's* home via mail. This is **not** part of the mail order pharmacy benefit. Extended day supplies and *Copayment* savings do not apply to these designated specialty drugs. Medications may be added to this program from time to time.

- **Non-Covered Drugs with Suggested Alternatives -** While *Tufts Health Plan* covers over 4,500 drugs, a small number of drugs (less than 1%) are not covered because there are safe, effective and more affordable alternatives available. Drugs may not be covered for safety reasons, if they are new on the market, if they become available over-the-counter, or if a generic version of a drug becomes available. These non-covered drugs are listed on the *Tufts Health Plan* website. All of the alternative drug products are approved by the U.S. Food and Drug Administration (FDA) and are widely used and accepted in the medical community to treat the same conditions as the medications that are not covered. For up-to-date information on these non-covered drugs and their suggested alternatives, please visit **tuftshealthplan.com/gic** or call *Member Services* at 800-870-9488.

- **New-To-Market Drug Evaluation Process -** New-to-market drug products are reviewed for safety, clinical effectiveness, and cost by *Tufts Health Plan's* Pharmacy and Therapeutics Committee. *Tufts Health Plan* then makes a coverage determination based on the Committee's recommendation. New drug products will not be covered until this process is completed – usually within 6 months of the product's availability.

- **Maintenance Choice Program –** Under the Maintenance Choice program, you can choose where to obtain maintenance medications for chronic conditions (i.e., hypertension, diabetes, or asthma). You may obtain a 30-day supply of maintenance medication from any retail pharmacy, or a 90-day supply from either the *Tufts Health Plan* designated mail order pharmacy, or a CVS/Pharmacy. The *Copayments* for a 90-day supply of these medications form the mail order or CVS Pharmacy provide cost savings over obtaining three 30-day supplies from retail pharmacies.
  - If you choose to obtain your maintenance medications through a retail pharmacy, you will be able to get the initial 30-day prescription and one 30-day refill at that pharmacy. **If you wish to continue filling your prescription at this pharmacy in 30-day supplies, you must opt out of the Maintenance Choice Program by calling CVS Caremark at 888-424-6618.** If you do not call to opt out of the program before refilling your prescription for a second time, you will be required to pay the full cost of the prescription. Please note that if you do opt out of the program, you will only be able to obtain up to a 30-day supply of the maintenance medication each time you refill the prescription and will pay higher costs than you would in the Maintenance Choice Program.

(continued on next page)

Tufts Health Plan Pharmacy Management Programs, continued

- **Split Fill Program --** This program applies only to certain medications. Medications in the Split Fill Program are dispensed in "split fills" with only a partial month's supply of the medication filled at a time. You will be responsible for paying a pro-rated *Cost Sharing Amount* instead of the *Cost Sharing Amount* for the full 1-30 day supply.

Notes:

- If your physician feels it is *Medically Necessary* for you to take medications that are restricted under any of the **Pharmacy Management Programs** described above, he or she may submit a request for coverage. *Tufts Health Plan* will review the request and provide you with notification of our coverage determination within 72 (seventy-two) hours after receiving the request. We will approve the request if it meets the guidelines for coverage. Please call Member Services at 800-870-9488 for more information.
- If a request is made to cover medications that are part of the "New-to-Market Drug Evaluation Process" program or the "Non-Covered Drugs with Suggested Alternatives" program, and that request is approved by *Tufts Health Plan*, the medications will generally be covered on Tier-3, with some exceptions. Please call Member Services at 800-870-9488 for more information.
- *Tufts Health Plan's* website has a list of covered drugs with their tiers. We may change a drug's tier during the year. For example, if a brand drug's patent expires, *Tufts Health Plan* may (a) move the brand drug from Tier-2 to Tier-3; or (b) add the brand drug to the list of non-covered drugs (see the website at **tuftshealthplan.com**) when a generic alternative becomes available. (Many generic drugs are available on Tier-1.)
- If you have questions about your prescription drug benefit, would like to know the tier of a particular drug, or would like to know if your medication is part of a Pharmacy Management Program, check **tuftshealthplan.com** or call Member Services at 800-870-9488.

Prescription Drug Benefit, Continued

Filling Your Prescription

Where to Fill Prescriptions

You can fill your prescriptions at any *Tufts Health Plan* designated pharmacy. For the majority of prescriptions, this includes most pharmacies in Massachusetts, New Hampshire, and Rhode Island and additional pharmacies nationwide. For a select number of drug products, you must fill your prescription through a small number of specially designated pharmacies. (For more information about *Tufts Health Plan's* special designated pharmacy program, see "**Pharmacy Management Programs"** earlier in this Prescription Drug Benefit section.)

> **Note:** Your prescription drug benefit is honored only at *Tufts Health Plan*-designated pharmacies. For information about reimbursement for your prescription drug claims in cases of *Emergency,* or about where to fill your prescription, please call Member Services at 800-870-9488.

How to Fill Prescriptions

Make sure the prescription is written by a participating *Plan* physician, except in cases of authorized referral or an *Emergency*. When you fill a prescription, **provide your member ID card to any *Tufts Health Plan* designated pharmacy**.

If the retail cost of your prescription is less than your *Copayment*, then you are only responsible for the actual retail cost.

Filling Prescriptions for Maintenance Medications:

If you are required to take any maintenance medications, *Tufts HP* offers you three choices for filling your prescription:

- Directly from a *Tufts HP* participating designated retail pharmacy for up to a 30-day supply
- Directly from a CVS Pharmacy for up to a 90-day supply; or
- Mailed to you through a *Tufts HP* designated mail services pharmacy for up to a 90-day supply (applies to most, but not all, maintenance medications). *Plan*-designated mail services pharmacies may not offer:
  - Medications for short-term medical conditions
  - Certain controlled substances and other prescribed drugs subject to exclusions or restrictions
  - Medications that are part of *Tufts Health Plan*'s Quantity Limitations or Special Designated Pharmacy programs.

For more information about maintenance medications, please see the "Maintenance Choice Program" on page 68.

Note: Your *Copayments* for maintenance medications are shown in the Prescription Drug Coverage Table below.

Exclusions from Benefits

The *Plan* does not cover a service, supply, or medication that is:

- Not *Medically Necessary*, as determined by *Tufts Health Plan*
- Not a *Covered Service*
- Not essential to treat an injury, illness, or pregnancy, except for preventive care services
- Able to be safely and effectively provided to you via a (a) less intensive level of service, supply, setting or medication, or (b) more cost-effective alternative
- Primarily for personal comfort or convenience
- Obtained from a non-*Plan Provider*. The only exceptions to this rule are for *Emergency* care services or *Urgent Care* services while traveling, or for *Covered Services* that are not available from a *Tufts HP Spirit Provider*, as described in "*Covered Services* Not Available from a *Tufts HP Spirit Provider*", on page 32.
- *Custodial Care*
- Related to non-*covered services*
- Charges for missed appointments that you do not cancel in advance, if the *Provider's* office policy is to charge for such appointments
- A drug, device, medical treatment or procedure (collectively "treatment") that is *Experimental or Investigative,* or for any related treatment

  Note: This exclusion does not apply to the following services, as per Massachusetts law: long-term antibiotic treatment of chronic Lyme disease; bone marrow transplants for breast cancer; patient care services provided pursuant to a qualified clinical trial; or the off-label uses of prescription drugs for the treatment of cancer or HIV/AIDS.

- Drugs, medicines, materials or supplies for use outside the hospital or any other facility, except as described earlier in Part 5
- Medications and other products that can be purchased without a prescription, except as listed earlier in Part 5
- Laboratory tests ordered by a *Member* (online or through the mail), even if performed at a licensed laboratory
- Provided by an immediate family member (by blood or marriage), even if the relative is a *Tufts HP Spirit Provider* and the services are authorized by your *PCP*. If you are a *Tufts HP Spirit Provider,* you cannot provide or authorize services for yourself, be your own *PCP*, or be the *PCP* of a member of your immediate family (by blood or marriage).
- Required by a third party (i.e., employer, insurance company, school, or court) and not otherwise *Medically Necessary*
- Services for which you are not legally obligated to pay or services for which no charge would be made if you had no health plan
- Care for conditions for which benefits are available under workers' compensation or other government programs other than Medicaid
- Care for conditions that state or local law requires be treated in a public facility
- Any additional fee a *Provider* may charge as a condition of access or any amenities that access fee is represented to cover. Refer to the *Tufts HP Spirit Provider Directory* to determine if your *Provider* charges such a fee.
- Charges incurred when the *Member*, for his or her convenience, chooses to remain an *Inpatient* beyond the discharge hour

Exclusions from Benefits, Continued

- Charges or claims incurred as a result, in whole or in part, of fraud or misrepresentation (e.g., claims for services not actually rendered and/or able to be validated)
- Facility charges or related services for a non-*Covered Service*
- Dental care and treatment, except as provided under "Oral Health Services" on page 50. Exclusions include, but are not limited to, preventive dental care; periodontal treatment; orthodontics; dental supplies; dentures; restorative services including, but not limited to, crowns, fillings, root canals, and bondings; skeletal jaw surgery (except as provided under "Oral health Services" on page 50); alteration of teeth; care related to deciduous (baby) teeth; splints and oral appliances (except for sleep apnea), including those for TMJ disorders.

  Note: This exclusion does not apply to the treatment of cleft lip or cleft palate for *Members* under 18, as described under "Cleft lip or cleft palate treatment and services for *Children*" earlier in this chapter.
- Surgical removal or extraction of teeth, except as provided under "Oral Health Services" on page 50.
- Cosmetic (i.e., meant to change or improve appearance) surgery, procedures, supplies, medications or appliances, except as provided under "Reconstructive surgery and procedures" on page 55.
  Note: Breast reconstruction following a *Medically Necessary* mastectomy is covered, as described in "Reconstructive surgery and procedures" (page 55).
- Rhinoplasty, except as provided under "Reconstructive surgery and procedures" on page 55; liposuction; the removal of tattoos; and brachioplasty
- Treatment of spider veins; removal or destruction of skin tags; treatment of vitiligo
- Hair removal (e.g., electroylysis, laser hair removal), except when *Medically Necessary* to treat an underlying skin condition or in relation to transgender genital surgery (with prior approval from an *Authorized Reviewer*).
- Costs associated with home births or services provided by a doula
- Circumcisions performed in any setting other than a hospital, *Day Surgery* facility, or a physician's office
- Infertility services, infertility medications and associated reproductive technologies (such as IVF, GIFT, and ZIFT) for *Members* who do not meet the definition of Infertility as described in the "Infertility services" benefit on page 45. Exclusions include, but are not limited to:
  - *Experimental* infertility procedures
  - The costs of surrogacy, including: (1) all costs (including, but not limited to, costs for drugs necessary to achieve implantation, embryo transfer, and cryo-preservation of embryos) incurred by a fertile woman to achieve a pregnancy as a surrogate or gestational carrier for an infertile *Member*; (2) use of donor egg and a gestational carrier; and (3) costs for maternity care if the surrogate is not a *Member*.
    - A surrogate is a person who carries and delivers a child for another either through artificial insemination or surgical implantation of an embryo.
    - A gestational carrier is a surrogate with no biological connection to the embryo/child.
  - Reversal of voluntary sterilization
  - Long-term (longer than 90 days) sperm or embryo cryopreservation not associated with active infertility treatment.

    Note: *Tufts HP* may authorize short-term (less than 90 days) cryopreservation of sperm, oocytes, or embryos for certain medical conditions that may impact a *Member's* future fertility. **Prior approval from an *Authorized Reviewer* is required.**
- Reversal of gender reassignment surgery
- Reversal of voluntary sterilization
- Over-the-counter contraceptive agents, except as described in the "Prescription Drug Benefit" earlier in this chapter
- The purchase of an electric hospital-grade breast pump; donor breast milk
- Human organ transplants, except as described on page 51. Expenses for transportation and lodging in connection with human organ transplants are not covered.

Exclusions from Benefits, Continued

- Services provided to a non-*Member*, except as described earlier in Part 5 for the following:
  - Organ donor charges under "Bone marrow transplants for breast cancer, hematopoietic stem cell transplants and human solid organ transplants" (see page 51)
  - Bereavement counseling services under “Hospice and end-of-life care services” (see page 57)
  - Procurement and processing of donor sperm, eggs, or embryos under “Infertility services” (to the extent such costs are not covered by the donor’s health coverage, if any).
- Acupuncture; biofeedback, except for the treatment of urinary incontinence; hypnotherapy; psychoanalysis; neuromuscular stimulators and related supplies; chiropractic services, except as described in “Chiropractic services” on page 43; chiropractic services (spinal manipulation services) for *Members* age 12 and under; any type of thermal therapy device; *Inpatient* and *Outpatient* weight-loss programs and clinics; exercise classes; relaxation therapies; massage therapies, except as described under “Short term physical and occupational therapy services” earlier in this chapter; services by a personal trainer; cognitive rehabilitation programs or cognitive retraining programs, except as described earlier in this chapter. Also excluded are diagnostic services related to any of these procedures or programs.
- All alternative, holistic, naturopathic, and/or functional health medicine services, supplies or procedures, and all services, procedures, labs and supplements associated with this type of medicine
- Any service, program, supply, or procedure performed in a non-conventional setting (including, but not limited to, spas/resorts; educational, vocational or recreational settings; Outward Bound; or wilderness, camp or ranch programs), even if performed or provided by licensed *Provider* (including, but not limited to, nutritionists, nurses or physicians).
- Blood, blood donor fees, blood storage fees, blood substitutes, blood banking, cord blood banking, and blood products

  Note: This exclusion does not apply to the following blood services and products:
  - Blood processing
  - Blood administration
  - Monoclonal and recombinant Factor products for Factor VIII deficiency (classic hemophilia), Factor IX deficiency (Christmas factor deficiency), and von Willebrand disease (prior approval from by an *Authorized Reviewer* is required)
  - Intravenous immunoglobulin for treatment of severe immune disorders, certain neurological conditions, infectious conditions, and bleeding disorders (prior approval from an *Authorized Reviewer* is required)
- Devices and procedures intended to reduce snoring including, but not limited to, laser-assisted uvulopalatoplasty, somnoplasty, and snore guards
- Multi-purpose general electronic devices, including, but not limited to, laptop computers, desktop computers, personal assistive devices (PADs), tablets, and smartphones. All accessories for multi-purpose general electronic devices, including USB devices and direct connect devices (e.g., speakers, microphones, cables, cameras, batteries, etc.). Internet and modem connection/access including, but not limited to, Wi-Fi®, Bluetooth®, Ethernet and all related accessories.
- Examinations, evaluations or services for educational purposes, including physical therapy, speech therapy, and occupational therapy, except as provided earlier in Part 5. Vocational rehabilitation services and vocational retraining. Also services to treat learning disabilities, behavioral problems, and services to treat speech, hearing and language disorders in a school-based setting.
- Eyeglasses, lenses or frames; or refractive eye surgery (including radial keratotomy) for conditions that can be corrected by means other than surgery. The Spirit Plan will not pay for eyeglasses, contact lenses or contact lens fittings, except as described in “Medical Appliances and Equipment” on page 59.
- Hearing aids or hearing aid fittings, except as described under "Medical Appliances and Equipment" on page 59.
- Methadone maintenance or methadone treatment related to substance use disorders. These services are covered under the mental health and substance use disorder benefit offered by Beacon Health Options (described later in this document).

Exclusions from Benefits, Continued

- Routine foot care, such as: trimming of corns and calluses; treatment of flat feet or partial dislocations in the feet; orthopedic shoes and related items that are not part of a brace; foot orthotics or fittings; or casting and other services related to foot orthotics or other support devices for the feet.

  Note: This exclusion does not apply to routine food care for *Members* diagnosed with diabetes. It also does not apply to therapeutic/molded shoes and shoe inserts for a *Member* with severe diabetic foot disease when (1) the need for therapeutic shoes and inserts has been certified by the *Member's* treating doctor, and (2) the shoes and inserts are prescribed by a *Provider* who is a podiatrist or other qualified doctor; and are furnished by a *Provider* who is a podiatrist, orthotist, prosthetist, or pedorthist.
- Transportation, including, but not limited to, transportation by chair car, wheelchair van, or taxi, except as described in "Ambulance services" on page 56
- Lodging related to receiving any medical service, including lodging related to obtaining gender reassignment surgery or related services

Part 6 - Member Satisfaction Process

Member Appeals Process

Tufts Health Plan ("*Tufts HP*") has a Member Satisfaction Process to address your concerns promptly. This process addresses:

- Internal Inquiry
- Member Grievance Process
- Appeals:
  - Internal Member Appeals, and
  - Expedited Appeals.

All grievances and appeals should be sent to *Tufts HP* at the following address:

Tufts Health Plan
Spirit Plan
Attn: Appeals and Grievances Department
705 Mt. Auburn Street
P.O. Box 9193
Watertown, MA 02471-9193
Fax: 617-972-9508

All calls should be directed to the Member Services Department at **800-870-9488.** Alternatively, you may submit your grievance or appeal at the address listed above.

Internal Inquiry
Call the Member Services Department at 800-870-9488 to discuss concerns you may have regarding your health care. Every effort will be made to resolve your concerns. If your concerns cannot be explained or resolved, or if you tell a Member Specialist that you are not satisfied with the response you have received from *Tufts HP,* we will notify you of any options you may have, including the right to have your inquiry processed as a grievance or appeal. If you choose to file a grievance or appeal, you will receive written acknowledgement and written resolution in accordance with the timelines outlined below.

Grievances
A grievance is a formal complaint about actions taken by *Tufts HP* or a *Tufts HP Spirit Provider.* There are two types of grievances: administrative grievances and clinical grievances. The two types of grievances are described below.

It is important that you contact *Tufts HP* as soon as possible to explain your concern. Grievances may be filed either verbally or in writing. If you choose to file a grievance verbally, please call a *Tufts HP* Member Specialist, who will document your concern and forward it to an Appeals and Grievances Analyst in the Appeals and Grievances Department. To accurately reflect your concerns, you may want to put your grievance in writing and send it to the address provided at the beginning of this section. Your explanation should include:

- Your name and address
- Your Member ID number
- A detailed description of your concern (including relevant dates, any applicable medical information, and *Provider* names)
- Any supporting documentation.

Note: The *Member* Grievance Process does not apply to requests for a review of a denial of coverage. If you are seeking such a review, please see the "Internal *Member* Appeals" section below.

Administrative Grievance
An administrative grievance is a complaint about a *Tufts HP* employee, department, policy, or procedure, or about a billing issue.

Note: Italicized words are defined in Part 8.

Member Appeals Process, continued

Administrative Grievance Timeline

- If you file your grievance in writing, *Tufts HP* will notify you by mail, within five (5) business days after receiving your letter, that your letter has been received and provide you with the name, address, and telephone number of the Appeals and Grievances Analyst coordinating the review of your grievance.
- If you file your grievance verbally, we will send you a written confirmation of our understanding of your concern within forty-eight (48) hours. We will also include the name, address, and telephone number of the person coordinating the review.
- *Tufts HP* will review your grievance and will send you a letter regarding the outcome within thirty (30) calendar days of receipt.
- The time limits in this process may be waived or extended upon mutual written agreement between you or your authorized representative and *Tufts HP.*

Clinical Grievances

A clinical grievance is a complaint about the quality of care or services that you have received from a *Tufts HP Spirit Provider*. If you have concerns about your medical care, you should discuss them directly with your *Provider.* If you are not satisfied with your *Provider's* response or do not wish to address your concerns directly with your *Provider,* you may contact Member Services to file a clinical grievance.

If you file your grievance in writing, we will notify you by mail within five (5) business days after receiving your letter, that your letter has been received and provide you with the name, address, and telephone number of the Appeals and Grievances Analyst coordinating the review of your grievance. If you file your grievance verbally, we will send you written confirmation of our understanding of your concerns within 48 hours. We will also include the name, address, and telephone number of the person coordinating the review.

Tufts HP will review your grievance and will notify you in writing regarding the outcome, as allowed by law, within 30 calendar days of receipt. The review period may be extended up to an additional 30 days if additional time is needed to complete the review of your concern. You will be notified in writing if the review timeframe is extended.

Internal Member Appeals

Requests for coverage that was denied as specifically excluded in this Spirit *Member Handbook* (or subsequent updates) or for coverage that was denied based on *medical necessity* determinations are reviewed as appeals through *Tufts Health Plan's* Internal Appeals Process. You may file a request yourself or you may designate someone to act on your behalf in writing. You have 180 days from the date you were notified of the denial of benefit coverage or claim payment to file your appeal.

(i) You can submit a verbal appeal of a benefit coverage decision to the Member Services Department, who will forward it to the Appeals and Grievances Department. You can also submit a written appeal to the address listed above under "Grievances". *Tufts HP* encourages you to submit your appeal in writing to accurately reflect your concerns. Your letter should include:

- Your complete name and address
- Your ID number
- A detailed description of your concern
- Copies of any supporting documentation.

You may also submit your appeal in person at the address listed at the beginning of this chapter.

(continued on next page)

Member Appeals Process, continued

Internal Member Appeals, continued

(ii) Within forty-eight (48) hours following *Tufts Health Plan's* receipt of your verbal or written appeal, a *Tufts Health Plan* Appeals and Grievances Analyst will send you an acknowledgment letter, a summary of our understanding of your concerns, and, if appropriate, a request for authorization for the release of your medical and treatment information related to your appeal.

Once you have signed and returned the authorization for the release of medical and treatment information to *Tufts Health Plan,* an Appeals and Grievances Analyst will document the date of receipt and coordinate the investigation of your appeal. In the event that you do not sign and return the authorization for the release of medical and treatment information to *Tufts Health Plan* within 30 calendar days of the day you requested a review of your case, *Tufts HP* may, in its discretion, issue a resolution of the appeal without reviewing some or all of your medical records.

(iii) The *Tufts Health Plan* Benefits Committee will review appeals concerning specific benefits and exclusions and make determinations. The *Tufts Health Plan* Appeals Committee will make utilization management (*medical necessity)* decisions. If your appeal involves an adverse determination (*medical necessity* determination), it will be reviewed by a medical director and/or a practitioner in the same or in a similar specialty that typically manages the medical condition, performs the procedure, or provides the treatment that is under review. The medical director and/or practitioner will not have previously reviewed your case.

(iv) The Appeals and Grievances Analyst will notify you in writing of the Committee's decision within no more than 30 calendar days of the receipt of your appeal. A copy of the decision will be sent to your physician, unless you request otherwise. A determination of claim denial will set forth:

- *Tufts Health Plan's* understanding of the request;
- The reason(s) for the denial;
- The specific contract provisions on which the denial is based
- The clinical rationale for the denial, if the appeal involves a *medical necessity* determination.

Tufts Health Plan maintains records of each inquiry made by a *Member* or by that *Member's* designated representative.

Expedited (Fast) Appeals

Tufts HP recognizes that there are urgent circumstances that require a quicker turnaround than the thirty (30) calendar days allotted for the standard Appeals Process. *Tufts HP* will expedite an appeal when your health may be in serious jeopardy or, in the opinion of your treating *Provider* (the practitioner responsible for the treatment or proposed treatment), you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal.

If your request meets the guidelines for an expedited (fast) appeal, it will be reviewed by a Medical Affairs Department Physician, Psychological Testing Reviewer, and/or practitioner in the same (or in a similar) specialty that typically manages the medical condition, performs the procedure or provides the treatment that is under review. This Medical Affairs Department Physician, Psychological Testing Reviewer, and/or practitioner will not have previously reviewed your case.

Your review will generally be conducted within two (2) business days, but not later than 72 hours (whichever is less) after *Tufts HP's* receipt of the request. If your appeal meets the guidelines for an expedited appeal, you may also file a request for a simultaneous external review as described below.

Member Appeals Process, continued

External Review

For certain types of claims, you or your authorized representative have the right to request an independent, external review of our Appeals decision. Should you choose to do so, send your request within four months of your receipt of written notice of the denial of your appeal to:

Tufts Health Plan
Appeals & Grievances Department
705 Mt. Auburn Street
Watertown, MA 02471-9193

Fax: 617-972-9509

In some cases, *Members* may have the right to an expedited (fast) external review. An expedited external review may be appropriate in urgent situations. An urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. Additionally, if *Tufts Health Plan* has not met all of our major procedural requirements (as listed above under internal appeals) for matters subject to external review, you can immediately file an external appeal.

If you request an external review, an independent organization will review the decision and provide you with a written determination. If this organization decides to overturn the appeal decision, the service or supply will be covered under the *Plan.*

If You Have Questions

If you have questions or need help submitting a grievance or an appeal, please call the Member Services Department at 800-870-9488 for assistance.

Bills from *Providers*

Bills from *Providers*

Occasionally, if you receive *Emergency* care or *Urgent Care* while traveling from a non-*Plan Provider*, you may receive a bill from the *Provider* for these *Covered Service*s. Before paying the bill, contact the *Tufts HP* Member Services Department.

If you do pay the bill, you must send the following information to the Member Reimbursement Medical Claims Department:

- A completed, signed Member Reimbursement Medical Claim Form, which can be obtained from the *Tufts HP* web site or by contacting the *Tufts HP* Member Services Department
- The documents listed on the Member Reimbursement Medical Claim Form

The address for the Member Reimbursement Medical Claims Department is listed on the Member Reimbursement Medical Claims Form.

> **Note:** You must contact *Tufts HP* regarding your bill(s) or send your bill(s) to *Tufts HP* within 24 months from the date of service. If you do not submit them in this timeframe, the bill cannot be considered for payment. Most completed reimbursement requests are processed within 30 days. Incomplete requests and requests for services rendered outside of the United States may take longer.

If you receive *Covered Service*s from a non-*Plan Provider* (i.e., *Emergency* or *Urgent Care* services), the *Plan* will pay up to the *Reasonable Charge* for the services. You are responsible for any amounts in excess of the *Reasonable Charge*, as well as the *Deductible*, *Coinsurance*, and/or *Copayments*.

Important Note:

Certain services you receive from non-*Plan Providers* at a *Tufts HP* facility may be reimburseable. Some examples of these types of *Providers* include *Emergency* room specialists and radiologists, pathologists, and anesthesiologists who work in *Tufts HP Spirit Hospitals*.

The *Plan* reserves the right to be reimbursed by the *Member* for payments made due to *Tufts HP*'s error.

Limitation on Actions

You cannot file a lawsuit against either Spirit or *Tufts Health Plan* for any claim under this health care program more than two (2) years after the Spirit *Plan* denies the claim, unless you do it within two (2) years of the time the cause of action arose. For example, if you want to file a lawsuit because you were denied coverage under the Spirit *Plan*, you must first complete our *Member* Satisfaction Process and then file your suit within two years of first being sent a notice of the denial. Going through our *Member* Satisfaction Process does not extend the time limit for filing a lawsuit beyond two years after the date you were first denied coverage.

Part 7 - Other *Plan* Provisions

Subrogation and Right of Recovery

The provisions of this section apply to all current and former plan participants and also to the parents, guardians, or other representatives of a *Dependent Child* who incurs claims and is or has been covered by the *Plan.* This *Plan's* right to recover (whether by subrogation or reimbursement) shall apply to the personal representatives of your estate, your decedents, minors, and incompetent or disabled persons. "You" and "your" includes anyone on whose behalf the *Plan* pays benefits. No adult *Subscriber* hereunder may assign any rights that it may have to recover medical expenses from any person or entity responsible for causing your injury, illness, or condition or any other person or entity to any minor child or children of said adult *Subscriber* without the prior express written consent of the *Plan*.

The *Plan's* right of subrogation or reimbursement, as set forth below, extend to al insurance coverage available to you due to an injury, illness, or condition for which the *Plan* has paid medical claims (including, but not limited to, any disability award or settlement, premises or homeowners' medical payments coverage, premises or homeowners' insurance coverage, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, no fault automobile coverage or any first party insurance coverage).

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds form any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interests are fully satisfied.

Subrogation
The right of subrogation means the *Plan* is entitled to pursue any claims that you may have in order to recover the benefits paid by the *Plan*. Immediately upon paying or providing any benefit under the plan, the plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the *Plan*. The *Plan* may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The *Plan* is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement
If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the *Plan* first from such payment for all amounts the *Plan* has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery. Benefit payments made under the plan are conditioned upon your agreement to reimburse the plan in full from any recovery you receive for your injury, illness, or condition.

Constructive Trust
By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any *Provider*), you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the *Plan.* No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the *Plan's* subrogation and reimbursement interest are fully satisfied.

Lien Rights
Further, the *Plan* will automatically have a lien to the extent of benefits paid by the *Plan* for the treatment of illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury, or condition for which the *Plan* paid benefits. The lien may be enforced against any party who possesses funds or proceeds represent the amount of benefits paid by the *Plan,* including, but not limited to, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the *Plan*.

Subrogation and Right of Recovery, continued

Subrogation Agent

Tufts Health Plan administers subrogation recoveries for the *Plan* and may contract with a third party to administer subrogation recoveries for the *Plan*. In such case, that subcontractor will act as *Tufts Health Plan's* agent.

Assignment

In order to secure the *Plan's* recovery rights, you agree to assign to the *Plan* any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the *Plan's* subrogation and reimbursement claims. This assignment allows the *Plan* to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting from the *Plan*, you acknowledge that the *Plan's* recovery rights are a first priority claim and are to be repaid to the *Plan* before you receive any recovery for your damages. The *Plan* shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the *Plan* will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The *Plan* is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the *Plan* is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical payments the *Plan* provided or purports to allocate any portion of such settlement or judgement to payments of expenses other than medical expenses. The *Plan* is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The *Plan's* claim will not be reduced due to your own negligence.

Cooperation

You agree to cooperate fully with the *Plan's* efforts to recover benefits paid. It is your duty to notify the *Plan* within 30 days of the date when any notice given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness, or condition. You and your agents agree to provide the *Plan* or its representatives notices of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice information requested by the *Plan*, *Tufts Health Plan* or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the *Plan* may reasonably request and all documents related to or filed in personal injury protection. Failure to provide this information, failure to assist the *Plan* in pursuit of its subrogation rights or failure to reimburse the *Plan* from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until:

- the *Plan* is reimbursed in full,
- termination of your health benefits, or
- the institution of court proceedings against you.

You shall do nothing to prejudice the *Plan's* subrogation or recovery interest or prejudice the *Plan's* ability to enforce the terms of this *Plan* provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the *Plan* or disbursement of any settlement proceeds or other recovery prior to fully satisfying the *Plan's* subrogation and reimbursement interest.

You acknowledge that the *Plan* has the right to conduct an investigation regarding the injury, illness, or condition to identify potential sources of recovery. The *Plan* reserves the right to notify all parties and his/her agents of lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the *Plan* has notified you that it has the right pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 *et seq*, to share your personal health information in exercising its subrogation and reimbursement rights.

Subrogation and Right of Recovery, continued

Workers' Compensation

Employers provide workers' compensation insurance for their employees to protect them in case of work-related illness or injury.

If you have a work-related illness or injury, you and your employer must ensure that all medical claims related to the illness or injury are billed to your employer's workers' compensation insurer. The *Plan* will not provide coverage for any injury or illness for which it determines that the *Member* is entitled to benefits pursuant to any workers' compensation statute or equivalent employer liability, or indemnification law (whether or not the employer has obtained workers' compensation coverage as required by law).

If the *Plan* pays for the costs of health care services or medications for any work-related illness or injury, the *Plan* has the right to recover those costs from you, the person, or company legally obligated to pay for such services, or from the *Provider*. If your *Provider* bills services or medications to the *Plan* for any work-related illness or injury, please contact the *Tufts Health Plan* Liability to Recovery Department at 1-888-880-8699, x. 21098.

Future Benefits

If you fail to cooperate with and reimburse the *Plan*, the health plan may deny any future benefit payments on any other claim made by your until the plan is reimbursed in full. However, the amount of any covered services excluded under this section will not exceed the amount of your recovery.

Coordination of Benefits

Benefits under other plans

You may have benefits under other plans for hospital, medical, dental or other health care expenses.

The Spirit Plan has a coordination of benefits program (COB) that prevents duplication of payment for the same health care services. We will coordinate benefits payable for *Covered Services* with benefits payable by other plans, consistent with state law.

Primary and secondary plans

The *Plan* will coordinate benefits by determining:

- Which plan (Spirit or your other plan(s)) has to pay first when you make a claim; and
- Which plan (Spirit or your other plan(s)) has to pay second.

These determinations will be made according to applicable state law and Division of Insurance regulations.

Right to receive and release necessary information

When you complete your membership application, you must include information on your membership application about other health coverage you have. After you enroll, you must notify *Tufts Health Plan* of new coverage or termination of other coverage. *Tufts Health Plan* may ask for and give out information needed to coordinate benefits.

You agree to provide information about other coverage and cooperate with *Tufts HP's* COB program.

Right to recover overpayment

The *Plan* may recover, from you or any other person or entity, any payments made that are greater than payments it should have made under the COB program. The *Plan* will only recover overpayments actually made.

For more information

For more information about COB, call the Liability and Recovery Department at 888-880-8699, ext. 21098.

Use and Disclosure of Medical Information

Use and disclosure of medical information
For information about how *Tufts Health Plan* uses and discloses your medical information, please contact the Member Services Department. Information is also available on the *Tufts Health Plan* website at **tuftshealthplan.com**.

For information about how the Commission uses and discloses your medical information, please contact the Commission.

Additional Plan Provisions

Tufts Health Plan* and *Providers
Tufts Health Plan arranges for health care services. *Tufts Health Plan* does not provide health care services. *Tufts Health Plan* has agreements with *Tufts HP Spirit Providers* practicing in their private offices throughout the *Spirit Service Area*. These *Providers* are independent. They are not Spirit's or *Tufts Health Plan's* employees, agents or representatives. *Providers* are not authorized to change this *Member Handbook* or assume or create any obligation for either Spirit or *Tufts Health Plan*.

Neither Spirit nor *Tufts Health Plan* is liable for the conduct of any *Provider,* including acts, omissions, representations, or any other behavior.

Acceptance of the terms of the Agreement
By enrolling in Spirit, *Subscribers* agree, on behalf of themselves and their enrolled *Dependents*, to all the terms and conditions of the Agreement between the *GIC* and *Tufts Health Plan*, including this *Member Handbook*.

Payments for coverage
Spirit is a self-funded plan. This means that the *GIC* is responsible for funding *Covered Services* for *Members* in accordance with the terms of the *Plan*.

Changes to this *Member Handbook*
The *GIC* may change this *Member Handbook*. Changes do not require any *Member's* consent. Notice of changes will be sent to *Subscribers* and will include the effective date of the change. The *Plan* is responsible for notifying you of changes. Changes will apply to all benefits for services received on or after the effective date.

Notice
Notice to *Members*: When *Tufts Health Plan* sends a notice to you, it will be sent to your last address on file with the *Group Insurance Commission*. For this reason, it is important for *Members* to keep their address current with the *GIC*.

Notice to *Tufts Health Plan*: *Members* should address all correspondence to:

Tufts Health Plan
Spirit Plan
705 Mt. Auburn Street
P.O. Box 9173
Watertown, MA 02471-9173

No Third Party Rights
The *Plan* grants rights to *Members*. It is not deemed to create rights in any third parties.

When this *Member Handbook* is Issued and Effective
This *Member Handbook* is issued and effective July 1, 2017 and supersedes all previous *Member Handbooks*.

Circumstances beyond *Tufts HP's* reasonable control
Tufts Health Plan is not responsible for a failure or delay to arrange for the provision of services due to circumstances beyond the reasonable control of *Tufts HP*. Such circumstances include, but are not limited to: major disaster, epidemic, war, riot, and civil insurrection. In such circumstances, *Tufts HP* will make a good faith effort to arrange for the provision of services.

Terms and Definitions

This section defines the terms used in this *Member Handbook*.

Adoptive Child
A *Child* is an *Adoptive Child* as of the date he or she:

- Is legally adopted by the *Subscriber*; or
- Is placed for adoption with the *Subscriber*. This means that the *Subscriber* has assumed a legal obligation for the total or partial support of a *Child* in anticipation of adoption. If the legal obligation ceases, the *Child* is no longer considered placed for adoption.

Annual Enrollment Period
The period each year when the *Group Insurance Commission* allows eligible persons to apply for and change coverage under Spirit and any other health plans the *GIC* offers.

Authorized Reviewer
Authorized Reviewers review and approve certain services and supplies to *Members*. *Authorized Reviewers* are either *Tufts Health Plan's Chief Medical Officer* (or equivalent) or someone he or she names to perform this function.

Child (Children)
The *Subscriber's* or *Spouse's Child* by birth, stepchild, or *Adoptive Child*, or any other *Child* for whom the *Subscriber* or *Spouse* has legal guardianship until the end of the month following their 26th birthday.

Coinsurance
The percentage of costs you must pay for certain *Covered Services*.

- For services provided by a non-*Plan Provider*, your share is a percentage of the *Reasonable Charge* for those services. You are responsible for costs in excess of the *Reasonable Charge.*
- For services provided by a *Tufts HP Spirit Provider*, your share is the lesser of:
    - A percentage of the applicable *Tufts Health Plan* fee schedule amount for those services; or
    - A percentage of the *Tufts HP Spirit Provider's* actual charges for those services.

Terms and Definitions, Continued

Contract Year

The 12-month period in which benefit limits and *Deductible* are calculated. The *Contract Year* (sometimes referred to as a plan year) runs from July 1st through June 30th and is designated by the *Group Insurance Commission.*

Copayment

Fees you pay for certain *Covered Services* provided or authorized by a *Tufts HP Spirit Provider*. *Copayments* are paid to the *Provider* when you receive care unless the *Provider* arranges otherwise. *Copayments* are not applied towards any *Deductible* or *Coinsurance*.

Copayment Tier 1 Specialist

A Massachusetts *Tufts HP* adult or pediatric specialist whose provider group (a) participates in the *GIC's* Centered Care Program and (b) provides the most efficient care.

Copayment Tier 2 Specialist

A Massachusetts *Tufts HP Spirit Provider* adult or pediatric specialist whose provider group (a) participates in the *GIC's* Centered Care Program and (b) provides less efficient care.

Copayment Tier 3 Specialist

A Massachusetts *Tufts HP* adult or pediatric specialist whose provider group does not participate in the *GIC's* Centered Care Program.

Cosmetic Services

Services performed solely for the purposes of improving appearance, which appearance is not the result of accidental injury, congenital anomaly or a previous surgical procedure or disease.

Covered Services

The services and supplies for which the *Plan* will pay. They must be:

- described in Part 5 of this *Member Handbook* (see pages 41-74);
- *Medically Necessary*, as determined by *Tufts Health Plan*; and
- in some cases, approved by an *Authorized Reviewer*.

Note: *Covered Services* include any surcharges on the plan such as the Massachusetts Health Safety Net Trust Fund or New York Health Care Reform Act surcharges, or later billed charges under provider network agreements, such as supplemental provider payments or access fee arrangements.

Custodial Care

- Care provided primarily to assist in the activities of daily living, such as bathing, dressing, eating, and maintaining personal hygiene and safety
- Care provided primarily for maintaining the *Member's* or anyone else's safety, when no other aspects of treatment require an acute hospital level of care
- Services that could be provided by people without professional skills or training
- Routine maintenance of colostomies, ileostomies, and urinary catheters
- Adult and pediatric day care

Note: *Custodial Care* is not covered by the *Plan*.

Day Surgery
Any surgical procedure(s) provided to a *Member* at a facility licensed by the state to perform surgery, and with an expected departure the same day. For hospital census purposes, the *Member* is an *Outpatient*, and not an *Inpatient*.

Deductible
The amount incurred by the *Member* for *Covered Services* before any payments are made under this *Member Handbook*. *Copayments* do not count towards any *Deductible.* See "Benefit Overview" at the front of this *Member Handbook* for more information.

Note: The amount credited towards the *Member's Deductible* is based on the *Tufts HP Spirit Provider* negotiated rate at the time the services are rendered. It does not reflect any later adjustments, payments, or rebates that are not calculated on an individual claim basis.

Dependent
The *Subscriber's Spouse*, former *Spouse*, *Child*, stepchild, eligible foster child, or *Handicapped Child*.

Developmental
Refers to a delay in the expected achievement of age-appropriate fine motor, gross motor, social, or language milestones that is not caused by an underlying medical illness or condition.

Durable Medical Equipment
Devices or instruments of a durable nature that are:

- *Medically Necessary*
- Prescribed by a physician
- Reasonable and necessary to sustain a minimum threshold of independent daily living
- Made primarily to serve a medical purpose
- Not useful in the absence of illness or injury
- Able to withstand repeated use
- Used in the home

Effective Date
The date, according to *Tufts Health Plan's* records, when you become a *Member* and are first eligible for *Covered Services*.

Emergency
An illness or medical condition, whether physical, behavioral, related to substance use disorder, or mental, characterized by symptoms of sufficient severity that the absence of prompt medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in:

- Serious jeopardy to the physical and/or mental health of a *Member,* another person, or a pregnant *Member's* unborn child;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part; or
- With respect to a pregnant woman who is having contractions, inadequate time to safely transfer to another hospital before delivery, or a threat to the safety of the *Member* or her unborn child if they were transferred to another hospital before delivery.

Some examples of illnesses or medical conditions requiring *Emergency* care are severe pain, a broken leg, loss of consciousness, vomiting blood, chest pain, difficulty breathing, suicidality, or any medical condition that is quickly worsening.

Experimental or Investigative

A service, supply, treatment, procedure, device, or medication (collectively "treatment") is considered *Experimental or Investigative* if **any** of the following apply:

- The drug or device cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished or to be furnished
- The treatment, or the "informed consent" form used for the treatment, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or federal law requires such review or approval
- Reliable evidence shows that the treatment is the subject of ongoing Phase I or Phase II clinical trials; is the research, experimental, study or investigative arm of ongoing Phase III clinical trials; or is otherwise under study to determine its safety, efficacy, toxicity, maximum tolerated dose, or its efficacy as compared with a standard means of treatment or diagnosis
- Evaluation by an independent health technology assessment organization has determined that the treatment is not proven safe and/or effective in improving health outcomes or that appropriate patient selection has not been determined
- The peer-reviewed published literature regarding the treatment is predominantly non-randomized, historically controlled, case controlled, or cohort studies, or there are few or no well-designed randomized, controlled trials

Family Plan

Coverage for a *Subscriber* and his or her *Dependents*.

Group Insurance Commission (GIC)

The Massachusetts state agency that provides health insurance for state and *Participating Municipality* employees, retirees, and their *Dependents.*

Habilitative

Health care services provided in accordance with the federal Affordable Care Act (ACA) in order for a person to attain, maintain or prevent deterioration of a life skill or function never learned or acquired due to a disabling condition. These services may include physical and occupational therapy, and speech-language pathology services in various *Inpatient* and *Outpatient* settings.

Handicapped Child

The *Subscriber's Child* who:

- Became permanently, physically or mentally disabled before age 19
- Is incapable of supporting himself or herself due to disability
- Was covered under the *Subscriber's Family Plan* immediately before reaching age 19 and who receives approval from the *GIC* to continue coverage under the *Family Plan*

Individual Contract

An agreement between *Tufts Health Plan* and the *Subscriber* under which *Tufts HP* agrees to provide *individual* coverage, and the *Subscriber* agrees to pay a premium to *Tufts HP*.

Individual Plan

Coverage for a *Subscriber* only (no *Dependents*)

Inpatient

A patient who is admitted to a hospital or other facility licensed to provide continuous care, and is classified as an *Inpatient* for all or a part of a day by that facility.

Inpatient Copayment Tier 1
The *Copayment* you are responsible for paying for an *Inpatient* admission in a *Tufts HP Spirit Hospital* whose provider group provides the most efficient care.

Inpatient Copayment Tier 2
The *Copayment* you are responsible for paying for an *Inpatient* admission in a *Tufts HP Spirit Hospital* whose provider group provides less efficient care.

Limited Service Medical Clinic
A walk-in medical clinic licensed to provide limited services, generally based in a retail store. Care is provided by a nurse practitioner. A limited service medical clinic offers an alternative to certain emergency room visits for a patient who needs less urgent care or is not able to visit his or her primary physician due to scheduling or other challenges. The services at a limited service medical clinic are only available to patients 24 months or older.

A limited medical service clinic does not provide *Emergency* or wound care, or treatment for injuries. It is not appropriate for people who need x-rays or stitches or who have life-threatening conditions. *Members* experiencing these conditions should go to an *Emergency* room.

Medically Necessary
A service or supply that is consistent with generally accepted principles of professional medical practice, as determined by whether it is:

- The most appropriate available supply or level of service for the *Member* in question considering potential benefits and harms to that individual
- Known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes
- Based on scientific evidence, for services and interventions not in widespread use.

In determining coverage for *Medically Necessary* Services, *Tufts HP* uses *Medical Necessity* coverage guidelines which are: Developed with input from practicing physicians in the *Tufts HP Spirit Service Area*, and in accordance with the standards adopted by national accreditation organizations; Updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and Evidence-based, if practicable.

Medical Supplies and Equipment
Items prescribed by a physician and which are *Medically Necessary* to treat disease and injury.

Member
A person enrolled in the Spirit Plan. Also referred to as "you."

Member Handbook
This document, including any future amendments, which describe the Spirit Plan.

Observation
The use of hospital services to treat and/or evaluate a condition that should result in either a discharge within forty-eight (48) hours or a verified diagnosis and concurrent treatment plan. At times, an *Observation* stay may be followed by an *Inpatient* admission to treat a diagnosis revealed during the period of *Observation.*

Outpatient

A patient who receives care other than on an *Inpatient* basis. This includes services provided in:

- a physician's office;
- a *Day Surgery* or ambulatory care unit; and
- an *Emergency* room or outpatient clinic.

Note: You are also an *Outpatient* when you are in a facility for *Observation*.

Out-of-Pocket Limit

The *Out-of-Pocket Limit* is the maximum amount of money paid by a *Member* during a *Contract Year* for *Covered Services*

An *Out-of-Pocket Limit* consists of the *Deductible, Coinsurance* and *Copayments.* It does not include any costs for health care services that are not *Covered Services,* costs in excess of the *Reasonable Charge,* or services or supplies listed in the "Note" for the "*Out-of-Pocket Limit"* provision on page 29.

Participating Municipality

A city, town or district of the Commonwealth of Massachusetts that participates in the health coverage offered by the *Group Insurance Commission*.

Plan

Spirit by Tufts Health Plan™, the *Group Insurance Commission's* self-funded plan administered by *Tufts Health Plan*, which provides you with the benefits described in this *Member Handbook*.

Plan Provider

A *Tufts HP Spirit Provider.*

Primary Care Provider

A *Tufts HP Spirit Provider* who is a general practitioner, family practitioner, internal medicine specialist, physician assistant, nurse practitioner, primary care physician who is also a specialist, obstetrician/gynecologist, or pediatric primary care provider who provides primary care services

Prosthetic Devices

Medically Necessary items (i.e., breast prostheses and artificial limbs) prescribed by a physician that replace all or part of a bodily organ or limb

Provider

A health care professional or facility licensed in accordance with applicable law including, but not limited to, hospitals, limited service medical clinics (if available), urgent care centers (if available), physicians, doctors of osteopathy, physician assistants, certified nurse midwives, certified registered nurse anesthetists, nurse practitioners, optometrists, podiatrists, licensed speech-language pathologists, and licensed audiologists.

The Spirit Plan will only cover services of a *Provider*, if those services are within the scope of the *Provider's* license and listed as *Covered Services* in Part 5 of this *Member Handbook* (see pages 41-74).

Provider Unit

A *Provider Unit* is comprised of doctors and other health care *Providers* who practice together in the same community and who often admit patients to the same hospital in order to provide their patients with a full range of care.

Reasonable Charge
The lesser of the

- Amount charged by the non-*Plan Provider*; or
- Amount that *Tufts Health Plan* determines to be reasonable, based upon nationally accepted means and amounts of claims payment. Nationally accepted means and amounts of claims payment include, but are not limited to: Medicare fee schedules and allowed amounts, CMS medical coding policies, AMA CPT coding guidelines, nationally recognized academy and society coding and clinical guidelines.

Routine Nursery Care
Routine care given to a well newborn *Child* immediately following birth until discharge from the hospital

Spirit Service Area
The geographical area within which *Tufts Health Plan* has developed a network of *Tufts HP Spirit Providers* to give *Members* adequate access to *Covered Services*. For more information about the *Spirit Service Area,* please call Member Services at 800-870-9488 or visit **tuftshealthplan.com/gic**.

Spouse
The *Subscriber's* legal spouse, according to the law of the state in which you reside.

Subscriber
The person who:

- Is an employee, a non-Medicare eligible retired employee, or non-Medicare eligible surviving spouse of an employee or retiree of the Commonwealth of Massachusetts or a *Participating Municipality*
- Enrolls in Spirit and signs the membership application form on behalf of himself or herself and any *Dependents*
- In whose name the premium contribution is paid.

Tobacco Cessation Counselor
Providers who are not physicians but who have completed at least eight (8) hours of instruction in tobacco cessation from an accredited institute of higher learning. Tobacco cessation counselors must work under the supervision of a physician.

Tufts Health Plan or Tufts HP
Total Health Plan, Inc., a Massachusetts Corporation d/b/a Tufts Health Plan. Tufts Health Plan enters into arrangements with groups or payers underwriting health benefit plans to make available a network of *Providers* and to provide certain administrative services to the health benefit plans including, but not limited to, processing claims for benefits and performing preregistration. *Tufts HP* does not insure the Spirit Plan.

Tufts HP Spirit Hospital
A hospital that has an agreement with *Tufts Health Plan* to provide certain *Covered Services* to *Members*. *Tufts HP Spirit Hospitals* are independent. They are not owned by *Tufts Health Plan*. *Tufts HP Spirit Hospitals* are not agents, representatives, employees of *Tufts Health Plan*.

Terms and Definitions, Continued

Tufts HP Spirit Provider

A *Provider* with whom *Tufts Health Plan* has an agreement to provide *Covered Services* to *Members. Tufts HP Spirit Providers* are not employees, agents or representatives of *Tufts Health Plan*.

Tufts Health Plan Spirit Provider Directory

A separate booklet which lists *Tufts HP Spirit Provider* physicians and their affiliated *Tufts HP Spirit Hospital.*

Note: This booklet is updated from time to time to show changes in *Tufts HP Spirit Providers.* For information about the *Providers* listed in the *Tufts HP Spirit Provider Directory*, please call Member Services at 800-870-9488 or visit **tuftshealthplan.com/gic**.

Urgent Care

Care provided when your health is not in serious danger, but you need immediate medical attention for an unforeseen illness or injury. Examples of illnesses or injuries in which *Urgent Care* might be needed are a broken or dislocated toe, a cut that needs stitches but is not actively bleeding, sudden extreme anxiety, or symptoms of a urinary tract infection.

Note: Care provided after the *Urgent* condition has been treated and stabilized and the *Member* is safe for transport is not considered *Urgent Care.*

Urgent Care Center

A medical facility (or clinic or medical practitioner office) that offers an alternative to certain emergency room visits for *Members* who are not able to visit their *Primary Care Provider* or health care *Provider* in a timely enough manner as warranted by their condition or symptoms. An *Urgent Care Center* does not provide *Emergency* care, and is not appropriate for people who have life-threatening conditions. To find an *Urgent Care Center* in our network, please visit our website at **tuftshealthplan.com** and click on “Find a Doctor.”

Part 10– Spirit Plan *Inpatient* Hospital *Copayment* Levels

Under the Spirit Plan, *Copayments* for *Inpatient* hospital stays at *Tufts HP Spirit Hospitals* are grouped into two *Inpatient* Hospital *Copayment Tiers*, which are based upon the efficiency in care they provide. (Please call Member Services for more information about hospital groupings.)

- *Tufts HP Spirit Hospitals* whose provider group provides the most efficient care are in ***Inpatient Copayment Tier 1***. *Inpatient* services at a *Tufts HP Spirit Hospital* included in *Inpatient Copayment Tier 1* are subject to a **$300 *Copayment*** per admission*****.
- *Tufts HP Spirit Hospitals* whose provider group provides less efficient care are in ***Inpatient Copayment Tier 2***. *Inpatient* services at a *Tufts HP Spirit Hospital* included in *Inpatient Copayment Tier* 2 are subject to a **$700 *Copayment*** per admission*.

  *Subject to the *Inpatient* Care *Copayment* Limit listed in the "*Inpatient* Care *Copayment* Limit" provision on page 28 of this Spirit *Member Handbook.*

There are other services for which the *Inpatient* Hospital *Copayment* Tiers do not apply. These include:

- Services for newborn *Children* who stay in the hospital beyond the mother's discharge **are subject to the *In-Network Deductible,* then covered in full.**
- Covered transplant services for *Members* **are subject to a $300 *Copayment* per admission*** when performed at a facility in *Tufts Health Plan's* designated transplant network. Covered transplant services for *Members* at any other *Tufts HP Spirit Hospital* are subject to a **$700 *Copayment* per admission.*** Any additional *Inpatient* admission to a *Tufts HP Spirit Hospital* for *Covered Services* related to the transplant procedure(s) is subject to the applicable *Inpatient Hospital Copayment.* Please see pages 93-94 of this Spirit *Member Handbook* for the *Copayment* amounts in effect as of July 1, 2017.
- *Copayments* are waived for readmissions within 30 days of discharge in the same *Contract Year*. If you are billed an *Inpatient Copayment* for a readmission within 30 days of discharge within the same *Contract Year,* please call Member Services to have your claim adjusted.

*****Subject to the *Inpatient* Care *Copayment* Limit listed in the "*Inpatient* Care *Copayment* Limit" provision on page 28 of this Spirit *Member Handbook.*

The Spirit *Inpatient* Hospital *Copayment* List, which appears in the following table, lists hospitals and their applicable *Copayments*.

Eastern Massachusetts

Hospital Name	*Inpatient Copayment*
Anna Jaques Hospital	$300
Beth Israel Deaconess Hospital – Milton	$300
Beth Israel Deaconess Hospital – Needham	$300
Beth Israel Deaconess Hospital - Plymouth	$300
Beth Israel Deaconess Medical Center	$300
Boston Medical Center	$300
Cambridge Hospital (part of Cambridge Health Alliance)	$300
Cape Cod Hospital	$300
Falmouth Hospital	$300
Hallmark Health Systems (Lawrence Memorial or Melrose Wakefield Hospitals)	$300
Lahey Hospital and Medical Center	$300
Lawrence General Hospital	$300
Lowell General Hospital	$300
Massachusetts Eye and Ear Infirmary	$300
Metrowest Medical Center - Framingham	$300
Metrowest Medical Center – Leonard Morse	$300
Mount Auburn Hospital	$300
New England Baptist Hospital	$300
Northeast Hospital Corporation (Addison Gilbert or Beverly Hospitals)	$300

Please note that the status and *Copayment* levels of our network of *Providers* listed above are in effect as of July 1, 2017. For the most up-to-date status, please contact Member Services at 800-870-9488.

Eastern Massachusetts, continued

Hospital Name	*Inpatient Copayment*
Signature Healthcare Brockton Hospital	$700
Southcoast Hospitals Group – Charlton Memorial Hospital	$300
Southcoast Hospitals Group – St. Luke's Hospital	$300
Southcoast Hospitals Group – Tobey Hospital	$300
South Shore Hospital	$700
Steward Carney Hospital	$300
Steward Good Samaritan Medical Center	$300
Steward Holy Family Hospital	$300
Steward Holy Family Hospital at Merrimack Valley	$300
Steward Morton Hospital and Medical Center	$300
Steward Norwood Hospital	$300
Steward Saint Anne's Hospital	$300
Steward St. Elizabeth's Medical Center	$300
Tufts Medical Center	$300
Winchester Hospital	$300

Please note that the status and *Copayment* levels of our network of *Providers* listed above are in effect as of July 1, 2017. For the most up-to-date status, please contact Member Services at 800-870-9488.

Central Massachusetts

Hospital Name	*Inpatient Copayment*
Athol Memorial Hospital	$700
Harrington Memorial Hospital	$700
Heywood Hospital	$700
Milford Regional Medical Center	$700
Steward Nashoba Valley Medical Center	$300
St. Vincent Hospital	$300

Western Massachusetts

Hospital Name	*Inpatient Copayment*
Baystate Medical Center	$300
Baystate Franklin Medical Center	$300
Baystate Noble Hospital	$300
Baystate Wing Hospital	$300
Berkshire Medical Center	$300
Fairview Hospital	$300
Holyoke Medical Center	$700
Mercy Medical Center	$300

Please note that the status and *Copayment* levels of our network of *Providers* listed above are in effect as of July 1, 2017. For the most up-to-date status, please contact Member Services at 800-870-9488.

Beacon Health Options

Mental Health, Substance Use Disorder, and Enrollee Assistance Programs

Description of Benefits

PART A -- HOW TO USE THIS PLAN

As a *member* of this plan, you are automatically enrolled in the mental health/substance use disorder benefits program, and the Enrollee Assistance Program (EAP), administered by Beacon Health Options (Beacon). Beacon offers easy access to a wide variety of services including assistance with day-to-day concerns and acute mental health and substance use disorder treatment. Beacon's comprehensive coverage ranges from traditional and intensive outpatient services to acute residential programs and inpatient care.

Beacon's *member*-driven and provider-centric approach seeks to improve your well-being and functioning as quickly as possible. Our primary goal is to offer you and your family "the right care, in the right setting, for the right amount of time" through our network of high quality, skilled providers.

Italicized words in this section are defined in Part C.

How to Contact Beacon Health Options

Phone	855-750-8980	**TTY: 711**
Website	**beaconhealthoptions.com/gic**	The website offers wellness articles, a Beacon *provider* directory, benefits information, and other helpful tools.
Hours of operation	**For specific benefits or claims questions:** Call a customer service representative Monday through Friday from 8 a.m. to 7 p.m., Eastern Time (ET). **For clinical support:** A qualified *Beacon clinician* will answer your call 24 hours a day, seven days a week, to verify your coverage and refer you to a specialized EAP resource or an *in-network provider.*	

How to Get Optimal Benefits

Taking two important steps will help you to receive the highest level of benefits and lower your out-of-pocket expenses:

Step 1: You must use a provider or facility that is part of the Beacon Health Options network. Except for urgent care while traveling or emergency care, there is no coverage for care from *out-of-network providers* under this plan.

Step 2: Call Beacon Health Options to obtain a referral for EAP services or to obtain *prior authorization* for *non-routine* outpatient and inpatient care. For a list of non-routine services, see the "Definitions of Beacon Health Options Behavioral Health Terms".

In-network providers -- Beacon has a comprehensive network of experienced providers, all of whom have met our rigorous credentialing process. These *in-network providers* – including providers in physical settings and telehealth providers -- offer you the highest level of quality care for mental health, substance use disorder, and EAP services.

Except for urgent care while traveling or emergency care, you must receive care from a provider or facility that is part of the Beacon network, or your benefit level will be reduced to zero. If you fail to call Beacon to obtain *prior authorization* (as indicated above) and referrals for your care, your benefits may be reduced. In some cases, if you or your provider fail to obtain *prior authorization* for *non-routine services*, no benefits will be paid.

Benefits will be denied if your care is not considered a covered service, or if you seek care from a provider that is not part of the Beacon network (except for urgent care while traveling or emergency care). Please refer to Part B, "Benefits" for a full description of your benefits.

We encourage you to call Beacon at 855-750-8980 (TTY: 711) before using your mental health, substance use disorder, or EAP benefits. A qualified *Beacon clinician* will answer your call 24 hours a day, seven days a week, to assist you with both routine and urgent matters. Our *clinicians* can verify your coverage and refer you to an *in-network provider* who matches your specific request (e.g., provider location, gender, or fluency in a second language). *Beacon clinicians* can also provide you with a referral for brief counseling, or legal, financial, or dependent care assistance through your EAP. Customer service representatives are also available from 8 a.m. to 7 p.m., Eastern Time (ET) to help you with specific benefits or claims questions.[1]

[1] Supervisors monitor random calls to Beacon Health Options' customer services department as part of Beacon's quality control program.

Referral/*Prior Authorization* for EAP and *Non-Routine Services*

You must obtain *prior authorization* for *non-routine outpatient services* and inpatient care requests. You must also obtain a referral from Beacon for EAP services. *Beacon clinicians* are available 24 hours a day, seven days a week at **855-750-8980 (TTY: 711)** to provide referrals and *prior authorization.*

After you obtain *prior authorization*, you can then call the provider of your choice directly to schedule an appointment. Beacon maintains an extensive database at **beaconhealthoptions.com/gic,** where you can search for *in-network providers.* You can also call Beacon for assistance finding an *in-network provider*.

If you (or your provider) do not call Beacon to obtain *prior authorization* or a referral, your benefits may be reduced or not paid at all.

Emergency Care

You should seek emergency care if you (or your covered dependents) need immediate clinical attention because you present a significant risk to yourself or others.

- In a life-threatening emergency, you should seek care immediately at the closest emergency facility.
- Beacon will not deny emergency care. However, **you, a family member or your provider must notify Beacon within 24 hours of an emergency admission.**

Although a representative may call on your behalf, it is always your responsibility to make certain that Beacon has been notified of an emergency admission. Your benefits may be reduced or denied if you do not notify Beacon.

> **Note:** If you call Beacon seeking non-life threatening emergent care, Beacon will connect you with appropriate services within six (6) hours.

Urgent Care

You should seek urgent care if you have a condition that may become an emergency if not treated quickly. In such situations, our providers will have appointments to see you within 48 hours of your initial call to Beacon. Contact Beacon at 855-750-8980 if you need assistance finding an *in-network provider* with urgent care appointment availability.

Routine Care

Routine care is appropriate if you have a condition that present no serious risk, and is not likely to become an emergency. *In-network providers* will have appointments to see you within ten days of your initial call to Beacon for routine care. Contact Beacon at 855-750-8980 if you need assistance finding an *in-network provider* with appointment availability.

Confidentiality

When you use your EAP, mental health and substance use disorder benefits under this plan, you consent to release necessary clinical records to Beacon for *case management* and benefit administration. This information is provided only to the extent necessary to administer and manage the care provided when you use your benefits, and in accordance with state and federal laws. All of your records, correspondence, claims, and conversations with Beacon staff are kept **completely confidential** in accordance with federal and state laws. No information may be released to your supervisor, employer or family without your written permission, and no one will be notified when you use your EAP, mental health and substance use disorder benefits. However, if you inform Beacon that you are seriously considering harming yourself or others, Beacon is legally required to notify emergency services to ensure your safety, even without your permission.

Coordination of Benefits (COB)

You and your dependents may be entitled to receive benefits from more than one plan. When this occurs, your plans use *coordination of benefits* to determine coverage for your mental health and substance use disorder benefits. All benefits under this plan are subject to *COB*. Beacon may request information from you about other health insurance coverage in order to process your claims.

PART B -- BENEFITS

BENEFITS EXPLAINED

Your *Member* Costs

Copayments (copays) – *Copays* are a set amount you pay when you get certain mental health or substance use disorder services. You have two different types of *copays* for behavioral health services under this plan:

- **Per-occurrence *copays* –** These are *copays* you pay every time you have a particular service. Outpatient visits all have per-occurrence *copays.*
- **Quarterly *copays* –** You pay quarterly *copays* only once per quarter, no matter how many times you get that service during the quarter. There are quarterly *copays* for inpatient and intermediate mental health and substance use disorder care. (The quarters are: July/August/September, October/November/December, January/February/March, and April/May/June.)

***Out-of-Pocket Limit* --** The *out-of-pocket limit* is the maximum amount you will pay in *copays* for your medical, pharmacy, mental health and substance use disorder care in one plan year. When you have met your *out-of-pocket limit*, all care will be covered at 100% for the *allowed amount* until the end of the year.

In-Network Benefits

Covered **in-network** services are paid at 100%, after *copays* (see the "Benefits Chart" below). If you receive multiple outpatient behavioral health services on the same day, from the same provider, you will only pay one *copay*. (The higher *copay* will apply.)

The ***out-of-pocket limit*** is $5,000 for one person and $10,000 for the entire family, shared with your in-network medical and pharmacy expenses. Only *in-network copays* apply to the in-network *out-of-pocket limit*. The cost of treatment that is subject to exclusions does not count toward the *out-of-pocket limit.* Once you reach your *out-of-pocket limit* in a year, all covered in-network services you receive are covered at 100% until the end of that plan year.

The following chart outlines your costs for mental health, substance use disorder, and EAP services.

BENEFITS CHART: MENTAL HEALTH, SUBSTANCE USE DISORDER, AND EAP

COVERED SERVICES	**IN-NETWORK COVERAGE**
Deductible	None
Out-of-Pocket Limit	$5,000 for one person, or $10,000 for the entire family Shared with applicable medical and pharmacy expenses
Inpatient Care[1]	
Mental Health General hospital psychiatric hospital **Substance Use Disorder** General hospital or Substance use disorder facility	$200 inpatient care *copay* per calendar quarter[2].
Intermediate Care[1] Including, but not limited to, crisis stabilization, acute residential treatment (Level 3.5), day/partial hospitals, structured outpatient treatment programs	$200 inpatient care *copay* per calendar quarter[2].

[1] You must obtain *prior authorization* for most inpatient, intermediate and hospital care. Please see chart titled "What This Plan Pays: Summary of *Covered Services*" (Part B) or call Beacon at 855-750-8980 for details. You must notify Beacon within 24 hours of emergency admissions to receive maximum benefits.
[2]Waived if readmitted within 30 days, with a maximum of one inpatient/*intermediate care copay* per calendar quarter.

(continued on next page)

Chart Continued…

COVERED SERVICE	**In-Network**
Outpatient Care – Mental Health, Substance Use Disorder, and Enrollee Assistance Program (EAP)	
Individual and Family Therapy[3]	$20 *copay*
Specialty Outpatient Services: Autism Spectrum Disorder services, ECT, TMS, psychiatric VNA, neuropsychological/psychological testing, acupuncture detox, and DBT.	$20 *copay*
Group Therapy Including Autism Spectrum Disorder group therapy visits	$15 *copay*
Medication management	$15 *copay*
Telehealth Services (online video-based counseling or medication management provided by American Well)[3]	$15 *copay*
Drug Screening (Urine) (In conjunction with *in-network* substance use disorder treatment)	No *copay*.
Enrollee Assistance Program **(EAP)** Including, but not limited to, depression, marital issues, family problems, alcohol and drug abuse, and grief. Also includes referral services – legal, financial, and child and elder care. **Note:** All EAP services require you to obtain a referral from Beacon. Failure to do so results in loss of coverage.	Counseling: Up to 3 visits per *member* per year, with no *copay*. Legal: 30-minute consultation with a local independent attorney and 25% off the hourly rate for service beyond the initial consultation. Financial: • 30-minute phone consultation with a financial counselor for assistance with issues such as credit repair, debt management, and budgeting. • 30-minute phone consultation with a local, independent financial planner, and 15% off his/her standard rate for preparing a financial plan.
Provider Eligibility: Provider must be independently licensed in their specialty area or working under the supervision of an independently licensed clinician in a facility or licensed clinic. Examples include: MD psychiatrist, PhD, PsyD, EdD, LICSW, LMHC, LMFT, RNCS, BCBA	

[3]You receive up to 26 medically necessary individual/family therapy visits per *member*, per plan year without *prior authorization*. *Prior authorization* is required for individual/family visits (including therapy done in conjunction with medical management) beyond 26 per benefit year

WHAT THIS PLAN PAYS: SUMMARY OF *COVERED SERVICES*[1]

The Plan pays for the services listed in the chart below. All services must meet medical necessity criteria to be covered.

Service	Applicable *Copay*/Co-insurance Type (see grid above for *copay* amounts)	*Prior Authorization* Required?
Acupuncture Withdrawal Management	Individual/Family Therapy	No
Acute Inpatient Psychiatric Services	Inpatient Care	Yes
Acute Residential Treatment	Intermediate Care	Yes
Adolescent Acute Inpatient Withdrawal Management and Rehabilitation for Substance Use Disorders (Level 3.5)	Inpatient Care	No
Adult Crisis Stabilization Unit (CSU)	Intermediate Care	Yes
Ambulatory Withdrawal Management	Medication Management	No
Applied Behavioral Analysis (ABA)	Individual/Family Therapy	Yes
Clinical Stabilization Services (CSS) for Substance Use Disorders (Level 3.5)	Intermediate Care	Notification of admission required within 48 hours
Community Based Acute Treatment (CBAT)	Intermediate Care	Yes
Community Support Programs (CSP)	Intermediate Care	Yes
Day Treatment	Intermediate Care	Yes
Dialectical Behavioral Therapy (DBT)	Individual/Family Therapy	Yes
Drug Screening (Urine) *In conjunction with substance use disorder treatment*	No *copay* (covered in-network only)	No
Dual Diagnosis Acute Treatment (DDAT) (Level 3.5)	Intermediate Care	Notification of admission within 48 hours.
Electroconvulsive Therapy (ECT)	Individual/Family Therapy	Yes
Emergency Service Programs (ESP)	No *copay*	No
Enrollee Assistance Program (EAP)	No *copay*	Yes (referral)
Family Stabilization Team (FST)	Intermediate Care	Yes
Group Therapy	Group Therapy	No
Individual/Family Therapy (conducted in the provider's office/facility, or, when appropriate, in a *member's* home	Individual/Family Therapy	*Prior authorization* is required for more than 26 visits per plan year
Inpatient Substance Use Disorder Services-Medically Managed (Level 4 detox)	Inpatient Care	Notification of admission required within 48 hours
Intensive Outpatient Programs (IOP) for Mental Health	Intermediate Care	No, for first 6 units within 14 days. Authorization required for subsequent units.
Intensive Outpatient Programs (IOP) for Substance Use Disorder (Level 2.1)	Intermediate Care	No, for first 6 units within 14 days. Authorization required for subsequent units.
Medication Management	Medication Management	No

Service	Applicable *Copay*/Co-insurance Type (see grid above for *copay* amounts)	*Prior Authorization* Required?
Methadone Maintenance	No *copay*	No
Observation	Inpatient Care	No
Partial Hospitalization Programs (PHP) for Mental Health	Intermediate Care	Yes
Partial Hospitalization Programs (PHP) for Substance Use Disorder (Level 2.5)	Intermediate Care	Notification of Admission required within 48 hours
Psychiatric Visiting Nurse services	Individual/Family Therapy	Yes
Psychological and Neuropsychological Testing	Individual/Family Therapy	Yes
Acute Residential Withdrawal Management-Medically Monitored/Acute Treatment Services (Level 3.7 Detox)	Intermediate Care	Notification of admission required within 48 hours
Structured Outpatient Addictions Programs (SOAP)	Intermediate Care	No authorization required for initial 20 units in 45 days per *member*. Authorization required for subsequent units.
Substance Use Disorder Assessment and Referral	No *copay*	No
Telehealth services (online video-based counseling or medication management from American Well or Beacon telehealth providers)	Telehealth services	Therapy: Prior authorization is required for more than 26 visits per plan year. Medication Management: No authorization required. Please call Beacon for referrals.
Transcranial Magnetic Stimulation (TMS)	Individual/Family Therapy	Yes
Transitional Care Unit (TCU) (for children in custody of Department of Children & Families)	Intermediate Care	Yes

[1]These services are subject to certain exclusions, which are found under "What's Not Covered – Exclusions" (Part B).
Failure to obtain *prior authorization,* when required, may result in no coverage. All services must be deemed *covered services* and all charges are subject to the Plan's *allowed amount* for that service.

COVERED SERVICES

Routine Services

Routine outpatient services (listed below) do not require *prior authorization.*

- Outpatient therapy (individual/family therapy, including therapy done in conjunction with medication management), up to 26 visits per *member*, per year
- Group therapy that is 45 to 50 minutes in duration
- Medication management, either in person or via telehealth
- Methadone maintenance
- In-network urine drug screening as a medically necessary part of substance use disorder treatment
- Emergency service programs (ESP)
- Telehealth services (online video based counseling up to 26 visits per member, per year)

Note: Outpatient therapy (including telehealth counseling) visits beyond 26 per benefit year are defined as *non-routine* and require *prior authorization.*

If you receive multiple outpatient behavioral health services on the same day, from the same provider, you will be charged one *copay* (The higher *copay* will apply).

Non-Routine Specialty Outpatient Services

You must obtain *prior authorization* for most *non-routine* outpatient care. Please see table "What This Plan Pays: Summary of Covered Services" for details on authorization requirements. Only *routine services* do not require *prior authorization.* Failure to obtain *prior authorization* for non-routine outpatient care may result in no coverage.

Note: Please see "Definitions of Beacon Health Options Behavioral Health Terms" (Part C) for a full listing of *non-routine* services.

If you receive multiple outpatient behavioral health services on the same day, from the same provider, you will be charged one *copay*. (The higher *copay* will apply).

Autism Spectrum Disorders-- The plan will cover medically necessary services provided for the diagnosis and treatment of autism spectrum disorders. Coverage is pursuant to the requirements of the plan and to Massachusetts law, including, without limitation: (1) professional services, including care by appropriately credentialed, licensed or certified psychiatrists, psychologists, social workers, and board-certified behavior analysts; and (2) habilitative/rehabilitative care, including, but not limited to, Applied Behavioral Analysis by a board-certified behavior analyst as defined by law.

Beacon's specialized autism case managers can provide any necessary *prior authorization* and help you locate an *in-network provider.* Please **call Beacon at 855-750-8980 to speak to an autism case manager.**

- **Applied Behavioral Analysis Services (ABA) --** Coverage for ABA-related services is based on medical necessity criteria. ***You must obtain prior authorization for all ABA services.*** Failure to obtain *prior authorization* may result in no coverage. Covered services include:
  - Skills assessment by a Board Certified Behavioral Analyst (BCBA) or qualified licensed clinician
  - Conjoint supervision of paraprofessionals by a BCBA or qualified licensed clinician, with clients present
  - Treatment planning conducted by a BCBA or qualified licensed clinician
  - Direct ABA services by a BCBA, licensed clinician, or paraprofessional (if appropriately supervised)
  - Direct ABA services by a paraprofessional or BCBA if appropriately supervised

- **Psychiatric services:** Psychiatric services for autism spectrum disorders are focused on treating maladaptive/stereotypic behaviors that pose a danger to self, others, and/or property, and impair daily functioning. Covered services include:
  - Treatment planning
  - Referral services
  - Medication management
  - Inpatient/24-hour supervisory care **(*prior authorization required*)**
  - Partial Hospitalization/Day Treatment **(*prior authorization required)***
  - Intensive Outpatient Treatment **(*prior authorization required*)**
  - Services at an Acute Residential Treatment Facility **(*prior authorization required*)**
  - Individual, family, therapeutic group, and provider-based case management services
  - Psychotherapy, consultation, and training session for parents and paraprofessional and resource support to family
  - Diagnostic evaluations and assessment support to family
  - Crisis Intervention
  - Transitional Care **(*prior authorization required*)**

Psychological Testing--You must obtain *prior authorization* for psychological testing, and for neuropsychological testing for mental health conditions. Failure to obtain *prior authorization* may result in no coverage.

Note: Neuropsychological testing for medical conditions is covered under the medical component of your plan.

Drug Screening (Urine) --

In-network urine drug screening is covered when it is a medically necessary part of substance use disorder treatment. (Screening that is conducted as part of methadone treatment is billed as part of the methadone services).

- Urine drug screening must be done by certified *in-network* providers. Beacon does not provide coverage for *out-of-network providers* or laboratories, or for *in-network providers* who are not certified.
- Urine drug screens completed by laboratories or *out-of-network providers* may be covered by the medical component of your plan. Contact Tufts Health Plan at 800-870-9488 for information about coverage under the medical component of your plan.

Intermediate Care

In-network *intermediate care* in a general or psychiatric hospital or a substance use disorder facility is covered at 100%, after a $200 *copay* per calendar quarter. The *copay* is waived if you are readmitted within 30 days of discharge.

You or your provider must obtain *prior authorization* for *intermediate care*. Failure to obtain *prior authorization* may result in no coverage.

Inpatient Care

In-network inpatient care in a general or psychiatric hospital or a substance use disorder facility is covered at 100%, after a $200 *copay* per calendar quarter. The *copay* is waived if you are readmitted within 30 days of discharge. If you are admitted to an *out-of-network* inpatient facility through an emergency room, and there are no *in-network providers* available, you will only be responsible for your in-network *copay*. Beacon will reimburse the facility the *out-of-network* allowed amount for the service. Please check with the facility to determine if you will be subject to balance billing.

If you require psychiatry visits/consultations while receiving inpatient care, these visits will be covered at 100%. **You or your provider must obtain *prior authorization* for inpatient care.** Failure to obtain *prior authorization* may result in no coverage.

Telehealth Services

Beacon is committed to providing access to quality behavioral health care when and where you need it. Beacon has enhanced our network by adding online video-based counseling services (telehealth), through American Well.

Telehealth services through American Well (AmWell) allows you to easily access a range of behavioral health services, including assessments, counseling, and medication management, from the comfort of your home. Telehealth is immediate, secure and confidential. It is also easy to use – all you need is a smartphone, tablet or computer with Internet access and a camera.

To schedule a live session with a Beacon AmWell telehealth provider, call Beacon's Member Services at 855-750-8980. A member services representative can either schedule your appointment or register you with American Well so you can choose a provider and schedule an appointment yourself. You can also directly register and search for a provider at amwell.com. All telehealth services received through AmWell are considered in-network, and will apply a $10 *copay*.

Beacon also offers telehealth services through your local in-network behavioral health providers. If you're interested in locating a local behavioral health provider that offers telehealth services, please contact Beacon Member Services at 855-750-8980 or log on to beaconhealthoptions.com/gic. All telehealth services are subject to a $10 in-network *copay*.

The following requirements apply to telehealth services:

- The provider you use must be licensed in the state in which you receive the services.
- There is no coverage for out-of-network telehealth services.
- For in-network telehealth services not received through American Well, in-network providers are required to sign Beacon's telehealth attestation form prior to claims approval.

Enrollee Assistance Program (EAP)

Beacon's **EAP** can help with the following types of problems:

1. Breakup of a relationship
2. Divorce or separation
3. Becoming a stepparent
4. Helping children adjust to new family members
5. Death of a friend or family member
6. Communication problems
7. Conflicts in relationships at work
8. Legal difficulties
9. Financial difficulties
10. Childcare or eldercare needs
11. Aging
12. Traumatic events

Call 1-855-750-8980 (TTY: 711) to use your EAP benefit. A *Beacon clinician* will refer you to a trained EAP provider and/or other specialized resource (e.g., attorney, dependent care service) in your community. *The Beacon clinician* may recommend mental health and substance use disorder services if the problem seems to require help that is more extensive than EAP services can provide.

You must call to receive a referral from Beacon for all EAP services. Failure to obtain a referral may result in no coverage.

Covered services include:

EAP Counseling Visits -- You have access to up to three EAP counseling visits per *member*, per year, with an *in-network* licensed provider. Telehealth counseling visits provided through American Well may qualify as EAP visits. EAP counseling visits can help with problems affecting work/life balance or daily living, such as marital problems, stress at work, or difficulties adjusting to life changes. These visits are covered at 100%.

Legal Services -- Legal assistance services include confidential access to a local attorney to help you answer legal questions, prepare legal documents and help solve legal issues. The following free or discounted services are provided through your legal benefit:

- Free referral to a local attorney
- Free 30-minute consultation (phone or in-person) per legal matter
- 25% off the attorney's hourly rate (if the attorney charges by the hour) for services beyond the initial consultation
- Free online legal information, including common forms and will kits

Financial Counseling and Planning – Your financial counseling and planning benefit include:

- A 30-minute initial phone consultation with a financial counselor for assistance with issues such as credit repair, debt management and budgeting.
- A 30-minute initial phone consultation with a local, independent financial planner, and 15% off his or her standard rate for preparing a financial plan.

Child/Elder Care Referral Service -- Beacon's EAP can help you locate a child or elder care provider. You will receive a packet that contains informational literature, links to federal and private agencies, and a list of independent referrals in your area. There is no cost for this referral service.

Domestic Violence Resources and Assistance -- You have 24/7 access to a confidential, toll-free hotline that provides crisis intervention, safety planning, supportive listening and help connecting to appropriate resources. Beacon's EAP can also provide referrals to a wide range of supportive services, including specialized counseling, temporary emergency housing, and legal assistance.

Employee Assistance Program for Agency Managers and Supervisors

The Group Insurance Commission offers an Employee Assistance Program for managers and supervisors of agencies and municipalities, which offers:

- Critical incident response services (also available to non-managers and supervisors),
- Confidential consultations
- Resources for dealing with employee problems such as low morale, disruptive workplace behavior, mental illness and substance use disorder.
- Team trainings on topics such as stress management and coping with challenging workplace behaviors.

Case Management

Beacon's clinical case managers are available to support you and your family. Case managers will:

- Help determine the appropriate treatment for you
- Review your case using the objective and evidence-based clinical criteria
- Help coordinate services among multiple providers
- Work with your providers to support your needs
- Provide available resources
- Work with your medical plan to help coordinate benefits and services
- Provide psychoeducation
- Encourage the development of a care plan to help with transitions in care

If you would like help dealing with your behavioral health situation, call Beacon at 855-750-8980 (TTY: 711) and ask to speak with a case manager.

WHAT'S NOT COVERED — EXCLUSIONS

This plan does not cover services, supplies or treatment relating to the below exclusions. The exclusions apply even if the services, supplies or treatment are recommended or prescribed by your provider, or if they are the only available options for your condition.

Excluded services include:

- Services performed in connection with conditions not classified in the most current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*.
- Prescription drugs or over-the-counter drugs and treatments. (**Note:** These services may be covered under the prescription drug component of your plan.)
- Services or supplies for mental health/substance use disorder treatment that, in Beacon's reasonable judgment, fits any of the following descriptions*:*
    - Is not consistent with the symptoms and signs for diagnosis and treatment of the behavioral disorder, psychological injury or substance use disorder
    - Is not consistent with prevailing national standards of clinical practice for the treatment of such conditions
    - Is not consistent with prevailing professional research, which would demonstrate that the service or supplies will have a measurable and beneficial health outcome
    - Typically does not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective; or that are consistent with Beacon's level of care clinical criteria, clinical practice guidelines, or best practices as modified from time to time.

  Beacon may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information.
- Services, supplies or treatments that are considered unproven, investigational, or experimental because they do not meet generally accepted standards of medical practice in the United States. The fact that a service, treatment or device is the only available treatment for a particular condition will not result in it being a *covered service* if it is considered to be unproven, investigational or experimental.
- Custodial care, unless necessary for acute stabilization or to return you to your baseline level of individual functioning. Care is considered custodial when it:
    - Is primarily intended for detention in a protected, controlled environment
    - Is chiefly designed to assist in the activities of daily living, or cannot reasonably be expected to restore you to a level of functioning that would enable you to function outside a structured environment. (This applies to *members* for whom there is little expectation of improvement, despite any and all treatment attempts.)
    - Is provided by a Department of Mental Health (DMH) continuing care facility or other DMH run program.
- Neuropsychological testing solely to determine a diagnosis of attention-deficit hyperactivity disorder.
    - **Note:** Neuropsychological testing for medical conditions is covered under the medical component of your plan.
- Urine drug screening is excluded when:
    - conducted as part of your participating in methadone treatment, which is billed as part of the methadone services
    - completed by *out-of-network providers*, laboratories, or *in-network providers* who are not certified
- Examinations or treatment, when:
    - required solely for purposes of career, education, housing, sports or camp, travel, employment, insurance, marriage, or adoption; or
    - ordered by a court except as required by law; or
    - conducted for purposes of medical research; or
    - required to obtain or maintain a license of any type

  Note: The above examinations or treatment may be covered if they are: (1) otherwise considered covered behavioral health services, and (2) determined by Beacon to be medically necessary.
- Herbal medicine, or holistic or homeopathic care, including herbal drugs or other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
- Biofeedback
- Equestrian or pet therapy
- Expenses related to service animals
- Any service, program, supply, or procedure performed in a non-conventional setting (including, but not limited to, spas/resorts; therapeutic/residential schools, educational, vocational, or recreational settings; daycare or preschool settings; Outward Bound; or wilderness, camp or ranch programs), even if performed or provided by licensed providers (including, but not limited to, nutritionists, nurses, or physicians).

- Multiple charges for the same service or procedure, on the same date
- Telehealth services provided out-of-network, or via non-HIPAA compliant technology (i.e., Skype, telephone), or performed by a provider who is not licensed in the state when the member receives the service.
- The cost of the necessary technology or equipment needed to provide HIPAA compliant telehealth services.
- Genetic testing for behavioral prescribing
- Services conducted by providers who are found to have sanctions against them
- Non=acute residential treatment, including, but not limited to, recovery residences, sober homes, Clinically Managed Low-Intensity Residential Services (Level 3.1), and Clinically Managed Population Specific High-Intensity Residential Services (Level 3.3).
- Acupuncture treatment (with the exception of acupuncture withdrawal management, which is a covered benefit).
- Facility charges for covered outpatient services
- Nutritional counseling. (**Note:** These services are covered under the medical component of your plan.)
- Weight reduction or control programs, special foods, food supplements, liquid diets, diet plans or any related products or supplies.
- Services or treatment rendered by unlicensed providers, including pastoral counselors (except as required by law), or services or treatment outside the scope of a provider's licensure.
- Personal convenience or comfort items, including, but not limited to, such items as TVs, telephones, computers, beauty or barber services, exercise equipment, air purifiers, or air conditioners.
- Light boxes and other equipment, including durable medical equipment, whether associated with a behavioral or non-behavioral condition.
- Private duty nursing services while confined in a facility.
- Surgical procedures including, but not limited to, gender reassignment surgery. (**Note:** The medical component of your plan provides coverage for many surgical procedures, including gender reassignment surgery.)
- Smoking cessation related services and supplies. (**Note:** These services and supplies are covered under the medical and prescription drug components of your plan.)
- Travel or transportation expenses, unless Beacon has requested and arranged for you to be transferred by ambulance from one facility to another.
- Services performed by a provider who is your family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
- Services performed by a provider with the same legal residence as you.
- Mental health and substance use disorder services that you have no legal responsibility to pay, or that would not ordinarily be charged in the absence of coverage under the plan.
- Charges in excess of any specified plan limitations.
- Charges for missed appointments.
- Charges for record processing except as required by law.
- Services provided under another plan
- Services provided under another plan, or services or treatment that must be purchased or provided through other arrangements under federal, state or local law. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation. Benefits will not be paid if you could have elected workers' compensation or coverage under a similar law (or could have it elected for you).
- Behavioral health services received as a result of war or any act of war (declared or undeclared) or caused during service in the armed forces of any country when you are legally entitled to other coverage
- Treatment or services received prior to your eligibility for coverage under the plan or after your coverage under the plan ends

PART C – DEFINITIONS, APPEALS, COMPLAINTS, AND GRIEVANCES

Definitions of Beacon Health Options Behavioral Health Terms

Appeal -- A formal request for Beacon to reconsider any adverse determination or denial of coverage for admissions, continued stays, levels of care, procedures, or services. Appeals can occur either concurrently or retrospectively.

Beacon Health Options (Beacon) Clinician -- A licensed master's level or registered nurse behavioral health clinician who provides *prior authorization* for EAP, mental health and substance use disorder services. *Beacon clinicians* have three or more years of clinical experience, Certified Employee Assistance Professionals (CEAP) certification or eligibility, and a comprehensive understanding of the full range of EAP services for employees and employers.

Case Management -- Beacon's clinical case managers can help support you and your family by helping to determine the appropriate treatment; reviewing your case, coordinating benefits and services; providing available resources; working with your providers; encouraging development of a care plan; and/or providing psychoeducation.

Complaint -- A verbal or written statement of dissatisfaction to Beacon concerning a perceived adverse administrative action, decision or policy.

Continuing review or concurrent review -- A clinical case manager works closely with the *provider* to determine the appropriateness of continued care, review the current treatment plan and progress, and to discuss your future care needs.

Coordination of Benefits (COB) -- You and your dependents may be entitled to receive benefits from more than one plan. When this occurs, your plans use coordination of benefits (COB) to determine the order and proportion of coverage for your mental health and substance use disorder benefits. COB regulations determine which insurer has primary responsibility for payment and pays first, and which insurer has secondary responsibility for any charges not covered by the primary plan.

Copayment (copay) -- A set amount you pay when you get certain mental health or substance use disorder services.

Cost-Sharing -- The amount that you pay for the cost of services. This includes any applicable *copays.*

Covered Services -- Services and supplies provided for the purpose of preventing, diagnosing, or treating a behavioral disorder, psychological injury, or substance use disorder. Covered services are described in "What This Plan Pays". The items under "What's Not Covered – Exclusions" are **not** covered services.

Intermediate Care -- Care that is more intensive that traditional outpatient treatment, but less intensive than 24-hour hospitalization. This includes, but is not limited to, partial hospitalization programs and acute residential withdrawal management.

In-Network Provider – A provider who participates in the Beacon network.

Member - A person who is enrolled in this plan through the Group Insurance Commission.

Non-Routine - Specialty services that require *prior authorization.* Non-routine services include:

- Individual/family outpatient therapy visits (including therapy conducted in conjunction with medication visits) beyond 26 visits per *member* in a year.
- Intensive outpatient treatment programs provided by a non-Massachusetts DPH-licensed provider
- Electroconvulsive treatment (ECT)
  - **Note**: Professional anesthesia services are covered under the medical component of your plan.
- Psychological testing
- Neuropsychological testing for a mental health condition
- Applied Behavioral Analysis (ABA)
- Transcranial Magnetic Stimulation (TMS)
- Acupuncture withdrawal management provided by a non-Massachusetts DPH-licensed provider.
- Ambulatory withdrawal management provided by a non-Massachusetts DPH-licensed provider:
- Community support programs
- Day treatment
- Dialectical Behavioral Therapy (DBT)
- Enrollee Assistance Program (EAP)
- Family stabilization team (FST)
- Psychiatric visiting nurse services

Out-of-Network Provider – A provider who does not participate in the Beacon network.

Out-of-Pocket Limit - The maximum amount you will pay in *copays* for your medical, mental health, and substance use disorder care in one plan year. When you have met your *out-of-pocket limit*, all care will be covered at 100% of the *allowed amount* until the end of the year.

Prior Authorization - The process of contacting Beacon prior to seeking non-routine mental health or substance use disorder care, or for a referral to Enrollee Assistance Program (EAP) services. All *prior authorization* is performed by *Beacon clinicians.*

Routine Services - A customary service that does not require *prior authorization.* Routine services include outpatient therapy (individual/family and telehealth counseling),up to 26 visits per *member* in a year, including therapy done in conjunction with medication management visits; group therapy of 45 to 50 minutes in duration; medication management and telehealth medication management; methadone maintenance; in-network urine drug screening as a medically necessary part of substance use disorder treatment; and emergency service programs (ESP). Outpatient therapy visits over 26 visits per year are considered non-routine and require *prior authorization*.

Filing Claims

In-network providers and facilities will file your claim for you. You are financially responsible for *copayments.* You must have been eligible for coverage on the date you received care, and treatment must be medically necessary. All claims are confidential.

Complaints

We encourage you to speak with a Beacon customer service representative if you are not satisfied with any aspect of our program. You can reach Beacon at 855-750-8980 (TTY: 711) Monday through Friday from 8 a.m. to 7 p.m., Eastern Time (ET). Beacon's *member* services representatives can resolve most inquiries during your initial call. Inquiries that require further research are reviewed by representatives of the appropriate departments at Beacon, including clinicians, claims representatives, administrators and other managers who report directly to senior corporate officers. We will respond to all inquiries within three (3) business days.

We want to hear from you. Your comments will help us correct any problems and provide better service to you and your dependents. If the resolution of your inquiry is unsatisfactory to you, you have the right to file a formal written *complaint* within 60 days of the date of our telephone call or letter of response. Beacon will respond to all formal *complaints* in writing within 30 days.

To submit a formal written *complaint* regarding a mental health or substance use disorder concern, please contact:

Ombudsperson
Beacon Health Options
500 Unicorn Park Drive, Suite 103
Woburn, MA 01801

Formal written *complaints* should include any information you feel is relevant. Please specify the dates of service and any additional contact you have had with Beacon.

Appeals

Your Right to an Internal *Appeal*

You, your treating provider, or someone acting on your behalf has the right to request an *appeal* of Beacon's benefit decisions. You may request an *appeal* by following the steps below.

> **<u>Note</u>: If your care needs are urgent (meaning that a delay in making a treatment decision could significantly increase your health risks or affect your ability to regain maximum function), please see the section below titled "How to Initiate an Urgently Needed Determination (Urgent Appeal)".**

How to Initiate a First Level Internal Appeal (Non-Urgent Appeal)
Your *appeal* request must be submitted to Beacon within **180 calendar days** of your receipt of the notice of the coverage denial.

Written requests should be submitted to the following address:

Beacon Health Options
Appeals Department
500 Unicorn Park Drive, Suite 103
Woburn, MA 01801
855-750-8980
Fax: 781-994-7636

Appeal requests must include:

- The *member's* name and identification number
- The date(s) of service(s)
- The provider's name
- The reason you believe the claim should be paid
- Any documentation or other written information to support your request for claim payment

The Appeal Review Process (Non-Urgent Appeal)

If you request an *appeal* review of a denial of coverage, the review will be conducted by someone who was not involved in the initial coverage denial, and who is not a subordinate to the person who issued the initial coverage denial.

- For a non-urgent *appeal* review, a *Beacon clinician* will review the denial and notify you of the decision, in writing, within 15 calendar days of your request.
- For an *appeal* review of a denial of coverage that already has been provided to you, Beacon will review the denial and will notify you in writing of Beacon's decision within 30 calendar days of your request.

You may bypass Beacon's internal review process and request an external review by an independent review organization, which will review your case and make a final decision, if:

- Beacon exceeds the time requirements for making a determination and providing notice of the decision; or
- Beacon continues to deny the payment, coverage or service requested

This process is described below in the "Independent External Review Process (Non-Urgent *Appeal*)" section.

Independent External Review Process (Non-Urgent Appeal)

You have the right to request an external review by an Independent Review Organization (IRO) of a decision made to not provide you a benefit or pay for an item or service (in whole or in part). Beacon is required by law to accept the determination of the IRO in this external review process.

You, your provider, or someone you consent to act for you (your authorized representative) can make this request. Requests must be made in writing within 180 calendar days of receipt of your non-coverage determination notice.

Written requests for independent external review should be submitted to the following address:

Beacon Health Options
Appeals Department
500 Unicorn Park Drive, Suite 103
Woburn, MA 01801
855-750-8980
Fax: 781-994-7636

Independent External Review requests must include:

- Your name and identification number
- The dates of service that were denied
- Your provider's name
- Any information you would like to have considered, such as records related to your current treatment, co-existing conditions, or any other relevant information you believe supports your *appeal*.

If you request an independent external review, Beacon will complete a preliminary review within five business days to determine if your request is complete and eligible for an independent external review.

Additional information about this process, and your *member* rights and *appeal* information, is available at **beaconhealthoptions.com/gic**, or by speaking with a Beacon representative.

How to Initiate an Urgently Needed Determination (Urgent Appeal)

Generally, an urgent situation is one in which your health may be in serious jeopardy, or if your physician believes that a delay in making a treatment decision could significantly increase the risk to your health or affect your ability to regain maximum function. If you believe your situation is urgent, contact Beacon immediately to request an urgent review. If your situation meets the definition of urgent, the review will be conducted on an expedited basis.

If you are requesting an urgent review, you may also request that a separate urgent review be conducted at the same time by an independent third party. You, your provider, or someone you consent to act for you (your authorized representative) may request a review. Contact Beacon if you would like to name an authorized representative on your behalf to request a review of the decision.

For an urgent review, Beacon will make a determination and will notify you verbally and in writing within 72 hours of your request. If Beacon continues to deny the payment, coverage or service requested, you may request an external review by an independent review organization that will review your case and make a final decision. This process is outlined in the "Independent External Review Process (Urgent Appeal)" section that follows.

Independent External Review Process (Urgent Appeal)

You have a right to request an external review by an Independent Review Organization (IRO) of a decision made to not provide you a benefit or pay for an item or service (in whole or in part). Beacon is required by law to accept the determination of the IRO in this external review process.

Requests can be made by you, your provider or someone you consent to act for you (your authorized representative). Requests must be made in writing within 180 calendar days of receipt of your non-coverage determination notice.

Written requests for independent external review should be submitted to the following address:

Beacon Health Options
Appeals Department
500 Unicorn Park Drive, Suite 103
Woburn, MA 01801
855-750-8980
Fax: 781-994-7636

Independent External Review requests must include:

- Your name and identification number
- The dates of service that were denied
- Your provider's name
- Any information you would like to have considered, such as records related to the current conditions of treatment, co-existent conditions, or any other relevant information.

If you request an independent external review, Beacon will complete a preliminary review immediately for an urgent request to determine if your request is complete and is eligible for an independent external review.

You can find additional information about this process and your *member* rights and *appeal* information at **beaconhealthoptions.com/gic**. You can also call 855-750-8980 (TTY: 711) to speak with a Beacon representative.

Group Insurance Commission Notices

GROUP *HEALTH* CONTINUATION COVERAGE UNDER COBRA
GENERAL NOTICE

This notice explains your COBRA rights and what you need to do to protect your right to receive it. You will receive a COBRA notice and application if the Group Insurance Commission (GIC) is informed that your current GIC coverage is ending due either to (1) end of employment, (2) reduction in hours of employment; (3) death of employee/retiree; (4) divorce or legal separation; or (5) loss of dependent child status. This COBRA notice contains important information about your right to temporarily continue your health care coverage in the Group Insurance Commission's (GIC's) health plan through a federal law known as COBRA. If you elect to continue your coverage, COBRA coverage will begin on the first day of the month immediately after your current GIC coverage ends.

You must complete the GIC COBRA Election Form and return it to the GIC by no later than 60 days after your group coverage ends by sending it by mail to the Public Information Unit at the GIC at P.O. Box 8747, Boston, MA 02114 or by hand delivery to the GIC, 19 Staniford Street, 4th floor, Boston, MA 02114. If you do not submit a completed election form by this deadline, you will lose your right to elect COBRA coverage.

WHAT IS COBRA COVERAGE? The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law under which certain former employees, retirees, spouses, former spouses and dependent children have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called 'Qualifying Events.' If you elect COBRA coverage, you are entitled to the same coverage being provided under the GIC's plan to similarly situated employees or dependents. The GIC administers COBRA coverage.

WHO IS ELIGIBLE FOR COBRA COVERAGE? Each individual entitled to COBRA (known as a "Qualified Beneficiary") has an *independent right* to elect the coverage, regardless of whether or not other eligible family members elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

If you are an employee of the Commonwealth of Massachusetts or municipality covered by the GIC's health benefits program, you have the right to choose COBRA coverage if

- You lose your group health coverage because your hours of employment are reduced; or
- Your employment ends for reasons other than gross misconduct.

If you are the spouse of an employee covered by the GIC's health benefits program, you have the right to choose COBRA coverage for yourself if you lose GIC health coverage for any of the following reasons (known as "qualifying events"):

- Your spouse dies;
- Your spouse's employment with the Commonwealth or participating municipality ends for any reason other than gross misconduct or his/her hours of employment are reduced; or
- You and your spouse legally separate or divorce.

If you have dependent children who are covered by the GIC's health benefits program, each child has the right to elect COBRA coverage if he or she loses GIC health coverage for any of the following reasons (known as "qualifying events"):

- The employee-parent dies;
- The employee-parent's employment is terminated (for reasons other than gross misconduct) or the parent's hours or employment are reduced;
- The parents legally separate or divorce; or
- The dependent ceases to be a dependent child under GIC eligibility rules

HOW LONG DOES COBRA COVERAGE LAST? By law, COBRA coverage must begin on the day immediately after your group health coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other qualifying events listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA coverage due to employment termination or reduction in hours, your family members' COBRA coverage may be extended beyond the initial 18-month period up to a *total* of 36 months (as measured from the initial qualifying event) if a second qualifying event – the insured's death or divorce - occurs during the 18 months of

COBRA coverage. **You must notify the GIC in writing within 60 days of the second qualifying event and before the 18-month COBRA period ends in order to extend the coverage**. Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. **You must provide the GIC with a copy of the Social Security Administration's disability determination within 60 days after you receive it and before your initial 18 month COBRA period ends in order to extend the coverage**.

COBRA coverage will end before the maximum coverage period ends if any of the following occurs:

- The COBRA cost is not paid ***in full*** when due (see section on paying for COBRA);
- You or another qualified beneficiary become covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary's pre-existing covered condition covered by COBRA benefits;
- You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability);
- The Commonwealth of Massachusetts or your municipal employer no longer provides group health coverage to any of its employees; or
- Any reason for which the GIC terminates a non-COBRA enrollee's coverage (such as fraud).

The GIC will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The GIC reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.

HOW AND WHEN DO I ELECT COBRA COVERAGE? Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. **If you do not elect COBRA coverage within the 60–day election period, you will lose all rights to COBRA coverage**.

In considering whether to elect COBRA coverage you should take into account that you have special enrollment rights under federal law, including the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan) within 30 days after your GIC coverage ends due to a qualifying event. You will also have the same special enrollment right at the end of COBRA coverage if you get continuation coverage for the maximum time available to you.

HOW MUCH DOES COBRA COVERAGE COST? Under COBRA, you must pay 102% of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150% of the applicable full cost rate for the additional 11 months of coverage. COBRA costs will change periodically; current COBRA rates are included with this notice.

HOW AND WHEN DO I PAY FOR COBRA COVERAGE? If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. **If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.**

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. **Services cannot be covered until the GIC receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period**. After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The GIC will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but **you are responsible for paying for the coverage even if you do not receive a monthly statement**. Payments should be sent to the GIC's address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make your monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. **If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.**

CAN I ELECT OTHER HEALTH COVERAGE BESIDES COBRA? Yes. You have the right to enroll, within 31 days after coverage ends, in an individual health insurance 'conversion' policy with your current health plan without providing proof of insurability. Alternately, if you are a Massachusetts resident, you may purchase health insurance through the Commonwealth's Health Connector Authority, or for employees in other states, through a Health Insurance Marketplace where available. The GIC has no involvement in conversion programs, and only very limited involvement in Health Connector programs. You pay the premium to the plan sponsor for the coverage. The benefits provided under such a policy might not be identical to those provided through COBRA. You may exercise this right in lieu of electing COBRA coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you.

YOUR COBRA COVERAGE RESPONSIBILITIES

- **You must inform the GIC of any address changes to preserve your COBRA rights;**
- **You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the qualifying events described above**. If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA coverage.
- **You must make the first payment for COBRA coverage within 45 days after you elect COBRA.** If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all COBRA coverage rights.
- **You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill**. If you do not make payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.
- **You must inform the GIC within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:**
- The employee's job terminates or his/her hours are reduced;
- The insured dies;
- The insured becomes legally separated or divorced;
- The insured or insured's former spouse remarries;
- A covered child ceases to be a dependent under GIC eligibility rules;
- The Social Security Administration determines that the employee or a covered family member is disabled; or
- The Social Security Administration determines that the employee or a covered family member is no longer disabled.

If you do not inform the GIC of these events within the time period specified above, you will lose all rights to COBRA coverage. To notify the GIC of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at Group Insurance Commission, P. O. Box 8747, Boston, MA 02114.

If you have questions about COBRA coverage, contact the GIC's Public Information Unit at 617/727-2301, ext. 1 or write to the Unit at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's website at **www.dol.gov/ebsa** or call their toll free number at 866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit **www.healthcare.gov** or, in Massachusetts visit, **www.mahealthconnector.org**.

Important Notice from the Group Insurance Commission (GIC) About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Plan and your options under Medicare's prescription drug coverage. This information can help you decide whether or not to join a non-GIC Medicare drug plan. If you are considering joining a non-GIC plan, you should compare your current coverage – particularly which drugs are covered, and at what cost – with that of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage can be found at the end of this notice.

FOR MOST PEOPLE, THE DRUG COVERAGE THAT YOU CURRENTLY HAVE THROUGH YOUR GIC HEALTH PLAN IS A BETTER VALUE THAN THE NON-GIC MEDICARE PART D DRUG PLANS.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available to everyone with Medicare in 2006. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The GIC has determined that the prescription drug coverage offered by your plan is, on average for all participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare Part D drug plan.

When Can You Join A Medicare Part D Drug Plan?
You can join a non-GIC Medicare drug plan when you first become eligible for Medicare and each subsequent year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period to join a non-GIC Medicare drug plan.

What Happens To Your Current Coverage If You Decide To Join A Non-GIC Medicare Drug Plan?

- If you enroll in another Medicare prescription drug plan or a Medicare Advantage plan with or without prescription drug coverage, you will be disenrolled from the GIC-sponsored CVS Caremark plan. If you are disenrolled from CVS Caremark, you will lose your GIC medical, prescription drug, and behavioral health coverage.
- If you are the insured and decide to join a non-GIC Medicare drug plan, both you and your covered spouse/dependents will lose your GIC medical, prescription drug, and behavioral health coverage.
- If you have limited income and assets, the Social Security Administration offers help paying for Medicare prescription drug coverage. Help is available online at **www.socialsecurity.gov** or by phone at 1-800-772-1213 (TTY 1-800-325-0778).

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with a GIC plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty)

as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage….
Contact the GIC at (617) 727-2310, extension 1. **NOTE:** You will receive this notice each year and if this coverage through the Group Insurance Commission changes. You may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for the telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227); TTY users should call 1-877-486-2048.

If you have limited income and assets, extra help paying for Medicare prescription drug coverage is available. For information about the Extra Help program, visit Social Security online at **www.socialsecurity.gov** or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Updated: November 2015

NOTICE OF GROUP INSURANCE COMMISSION PRIVACY PRACTICES

Effective September 3, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the GIC must protect the privacy of your personal health information. The GIC retains this type of information because you receive health benefits from the Group Insurance Commission. Under federal law, your health information (known as "protected health information" or "PHI") includes what health plan you are enrolled in and the type of health plan coverage you have. This notice explains your rights and our legal duties and privacy practices.

The GIC will abide by the terms of this notice. Should our information practices materially change, the GIC reserves the right to change the terms of this notice, and must abide by the terms of the notice currently in effect. Any new notice provisions will affect all protected health information we already maintain, as well as protected health information that we may receive in the future. We will mail revised notices to the address you have supplied, and will post the updated notice on our website at www.mass.gov/gic.

Required and Permitted Uses and Disclosures

We use and disclose protected health information ("PHI") in a number of ways to carry out our responsibilities. The following describes the types of uses and disclosures of PHI that federal law requires or permits the GIC to make *without* your authorization:

Payment Activities: The GIC may use and share PHI for plan payment activities, such as paying administrative fees for health care, paying health care claims, and determining eligibility for health benefits.

Health Care Operations: The GIC may use and share PHI to operate its programs that include evaluating the quality of health care services you receive, arranging for legal and auditing services (including fraud and abuse detection); and performing analyses to reduce health care costs and improve plan performance.

To Provide You Information on Health-Related Programs or Products: Such information may include alternative medical treatments or programs or about health-related products and services, subject to limits imposed by law as of September 23, 2013

Other Permitted Uses and Disclosures: The GIC may use and share PHI as follows:

- to resolve complaints or inquiries made by you or on your behalf (such as appeals);
- to enable business associates that perform functions on our behalf or provide services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract. Our business associates are also directly subject to federal privacy laws**;**
- for data breach notification purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access or disclosure of your health information;
- to verify agency and plan performance (such as audits);
- to communicate with you about your GIC-sponsored benefits (such as your annual benefits statement);
- for judicial and administrative proceedings (such as in response to a court order);
- for research studies that meet all privacy requirements; and
- to tell you about new or changed benefits and services or health care choices.

Required Disclosures: The GIC **must** use and share your PHI when requested by you or someone who has the legal right to make such a request on your behalf (your Personal representative), when requested by the United States Department of Health and Human Services to make sure your privacy is being protected, and when otherwise required by law.

Organizations That Assist Us: In connection with payment and health care operations, we may share your PHI with our third party "Business Associates" that perform activities on our behalf, for example, our Indemnity Plan administrator. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked of them. These business associates will be contractually bound to safeguard the privacy of your PHI and also have direct responsibility to protect your PHI imposed by federal law.

Except as described above, the GIC will not use or disclose your PHI without your written authorization. You may give us written authorization to use or disclose your PHI to anyone for any purpose. You may revoke your authorization so long as you do so in writing; however, the GIC will not be able to get back your health information we have already used or shared based on your permission.

Your rights

You have the right to:

- Ask to see and get a copy of your PHI that the GIC maintains. You must ask for this in writing. Under certain circumstances, we may deny your request. If the GIC did not create the information you seek, we will refer you to the source (e.g., your health plan administrator). The GIC may charge you to cover certain costs, such as copying and postage.
- Ask the GIC to amend your PHI if you believe that it is wrong or incomplete and the GIC agrees. You must ask for this by in writing, along with a reason for your request. If the GIC denies your request to amend your PHI, you may file a written statement of disagreement to be included with your information for any future disclosures.
- Get a listing of those with whom the GIC shares your PHI. You must ask for this in writing. The list will not include health information that was: (1) collected prior to April 14, 2003; (2) given to you or your personal representative; (3) disclosed with your specific permission; (4) disclosed to pay for your health care treatment, payment or operations; or (5) part of a limited data set for research;
- Ask the GIC to restrict certain uses and disclosures of your PHI to carry out payment and health care operations; and disclosures to family members or friends. You must ask for this in writing. Please note that the GIC will consider the request, but we are not required to agree to it and in certain cases, federal law does not permit a restriction.
- Ask the GIC to communicate with you using reasonable alternative means or at an alternative address, if contacting you at the address we have on file for you could endanger you. You must tell us in writing that you are in danger, and where to send communications.
- Receive notification of any breach of your unsecured PHI.
- Receive a separate paper copy of this notice upon request. (An electronic version of this notice is on our website at www.mass.gov/gic.)

If you believe that your privacy rights may have been violated, you have the right to file a complaint with the GIC or the federal government. GIC complaints should be directed to: GIC Privacy Officer, P.O. Box 8747, Boston, MA 02114. Filing a complaint or exercising your rights will not affect your GIC benefits. To file a complaint with the federal government, you may contact the United States Secretary of Health and Human Services. To exercise any of the individual rights described in this notice, or if you need help understanding this notice, please call (617) 727-2310, extension 1 or TTY for the deaf and hard of hearing at (617)-227-8583.

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

The uniformed Services Employment and Reemployment Rights Act (USERRA) protects the rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services. The GIC has more generous guidelines for benefit coverage that apply to persons subject to USERRA, as set forth below:

> If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents while in the military.
>
> Service members who elect to continue their GIC health coverage are required to pay the employee's share for such coverage.
>
> Even if you don't elect to continue coverage during your military service, you have the right to be reinstated to GIC health coverage when you are reemployed, generally without any waiting periods or exclusions except for service-connected illnesses or injuries.

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its **website at http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/elaws/userra.htm**. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA. The rights listed here may vary depending on the circumstances.

For more information about your GIC coverage, please contact the Group Insurance Commission at (617) 727-2310, ext. 1.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 12/31/2019)

PATIENT PROTECTION DISCLOSURE

This plan generally requires the designation of a *Primary Care Provider*. You have the right to designate any primary care provider who participates in our network and who is available to accept you and/or your family members. For information on how to select a *Primary Care Provider,* and for a list of the participating *Primary Care Providers,* contact Member Services or see our Web site at http://tuftshealthplan.com.

For *Children*, you may designate a pediatrician as the *Primary Care Provider.*

You do not need prior authorization from *Tufts Health Plan* or from any other person (including a *Primary Care Provider*) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specializes in obstetrics or gynecology, contact Member Services or see our Web site at http://tuftshealthplan.com.

The Commonwealth of Massachusetts

MASSACHUSETTS HEALTH CONNECTOR
the right place for the right plan

YOU ARE RECEIVING THIS NOTICE AS REQUIRED BY THE NEW NATIONAL HEALTH REFORM LAW (ALSO KNOWN AS THE AFFORDABLE CARE ACT OR ACA)

On January 1, 2014, the Affordable Care Act (ACA) will be implemented in Massachusetts and across the nation. The ACA will bring many benefits to Massachusetts and its residents, helping us expand coverage to more Massachusetts residents, making it more affordable for small businesses to offer their employees healthcare, and providing additional tools to help families, individuals and businesses find affordable coverage. This notice is meant to help you understand health insurance Marketplaces, which are required by the ACA to make it easier for consumers to compare health insurance plans and enroll in coverage. In Massachusetts, the state Marketplace is known as the Massachusetts Health Connector. While you may or may not qualify for health insurance through the Health Connector, it may still be helpful for you to read and understand the information included here.

Overview: When key parts of the national health reform law take effect in January 2014, there will be an easy way for many individuals and small businesses in Massachusetts to buy health insurance: the Massachusetts Health Connector. This notice provides some basic information about the Health Connector, and how coverage available through the Health Connector relates to any coverage that may be offered by your employer. You can find out more by visiting: **MAhealthconnector.org**, or for non-Massachusetts residents, **Healthcare.gov** or (1-800-318-2596; TTY: 1-855-889-4325).

What is the Massachusetts Health Connector? The Health Connector is our state's health insurance Marketplace. It is designed to help individuals, families, and small businesses find health insurance that meets their needs and fits their budget. The Health Connector offers "one-stop shopping" to easily find and compare private health insurance options from the state's leading health and dental insurance companies. Some individuals and families may also qualify for a new kind of tax credit that lowers their monthly premium right away, as well as cost sharing reductions that can lower out-of-pocket expenses. This new tax credit is enabled by §26B of the Internal Revenue Service (IRS) Code.

Open enrollment for individuals and families to buy health insurance coverage through the Health Connector begins Oct. 1, 2013, for coverage starting as early as Jan. 1, 2014. (And in future years, open enrollment will begin every Oct. 15.) You can find out more by visiting **MAhealthconnector.org** or calling **1-877-MA ENROLL** (1-877-623-6765).

Can I qualify for federal and state assistance that reduces my health insurance premiums and out-of-pocket expenses through the Health Connector?

Depending on your income, you may qualify for federal and/or state tax credits and other subsidies that reduce your premiums and lower your out-of-pocket expenses if you shop through the Health Connector. You can find out more about the income criteria for qualifying for these subsidies by visiting **MAhealthconnector.org** or calling **1-877-MA ENROLL** (1-877-623-6765).

Does access to employer-based health coverage affect my eligibility for subsidized health insurance through the Health Connector?

An offer of health coverage from the Commonwealth of Massachusetts, as the employer, could affect your eligibility for these credits and subsidies through the Health Connector. If your income meets the eligibility criteria, you will qualify for credits and subsidies through the Health Connector if:

- **The Commonwealth of Massachusetts does not offer coverage to you**, or

- **The Commonwealth of Massachusetts offers you coverage, but:**
    - The coverage the Commonwealth of Massachusetts provides you (not including other family members) would require you to spend more than 9.5 percent of your household income for the year; or
    - The coverage the Commonwealth of Massachusetts provides does not meet the "minimum value" standard set by the new national health reform law (which says that the plan offered has to cover at least 60 percent of total allowed costs)

If you purchase a health plan through the Health Connector instead of accepting health coverage offered by the Commonwealth of Massachusetts please note that you will lose the employer contribution (if any) for your health insurance. Also, please note that the amount that you and your employer contribute to your employer-sponsored health insurance is often excluded from federal and state income taxes. Health Connector premiums have different tax treatment.

As part of considering whether the ACA and Marketplaces will affect you as an employee it is important to understand what the Commonwealth of Massachusetts offers you.

- The Commonwealth offers benefited employees health coverage through the Group Insurance Commission. To be eligible for GIC health insurance, a state employee must work a minimum of 18 ¾ hours in a 37.5 hour workweek or 20 hours in a 40 hour workweek. The employee must contribute to a participating GIC retirement system, such as the State Board of Retirement**,** a municipal retirement board, the Teachers Retirement Board, the Optional Retirement Pension System for Higher Education**,** a Housing, Redevelopment Retirement Plan, or another Massachusetts public sector retirement system (OBRA is not such a public retirement system for this purpose. Visit www.mass.gov/gic or see your GIC Coordinator for more information.

- Temporary employees, contractors, less-than-half time part time workers, and most seasonal employees are not eligible for GIC health insurance benefits. These employees may shop for health insurance through the Health Connector and may be eligible for advanced premium federal tax credits and/or state subsidies if their gross family income is at or below 400% Federal Poverty Level (which is approximately $46,000 for an individual and $94,000 for a family of four). Visit www.MAhealthconnector.org or call 1-877-MA-ENROLL for more information.

If there is any confusion around your employment status and what you are eligible for, please email healthmarketplacenotice@massmail.state.ma.us or contact your HR department or GIC Coordinator.

ANTI-DISCRIMINATION NOTICE

Tufts Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Tufts Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Tufts Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact Tufts Health Plan at 800.462.0224.

If you believe that Tufts Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Tufts Health Plan
Attention: Civil Rights Coordinator Legal Dept.
705 Mount Auburn St. Watertown, MA 02472
Phone: 888.880.8699 ext. 48000, [TTY number — 800.439.2370 or 711]
Fax: 617.972.9048
Email: OCRCoordinator@tufts-health.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Tufts Health Plan Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

tuftshealthplan.com | 800.462.0224

Index

This index lists the major benefits and limitations of the Spirit plan. Of course, it does not list everything in this *Member Handbook*. To fully understand all benefits and limitations, a *Member* must read through this *Member Handbook* carefully.

Need to Write or Call?

Tufts Health Plan
705 Mt. Auburn Street, P.O. Box 9173
Watertown, MA 02471-9173

800.870.9488

For the Enrollee Assistance Program or
Mental Health/Substance Use Disorder Treatment,
please call Beacon Health Options

855.750.8980

Commonwealth of Massachusetts
Group Insurance Commission

TUFTS
Health Plan

Tufts Health Plan Spirit

Tufts Health Plan
705 Mt. Auburn Street
Watertown, MA 02472

For additional information,
please call 800.870.9488

tuftshealthplan.com

Administered by Total Health Plan, Inc.

GIC-SPIPPO-001 Ed. 7-2017